# Paul M. Figlia MD, PA

Patient Registration Form

Member of the American Society for Aesthetic Plastic Surgery
The Mark of Distinction In Cosmetic Plastic Surgery®

AMERICAN SOCIETY OF PLASTIC SURGEONS

Reason for Visit: _____ Today`s Date: _____

Referred by: Dr. or Hospital (please circle) if so _____

Patient Name: **First**:_____ Middle:_____ **Last**:_____

**Address**:_____
**Street** **City** **State** **Zip**

**Home Phone:** _____ **Cell:** _____ Work:_____

**Date of Birth**:_____ SS #: _____

**Sex:** Male _____ Female _____ Marital Status:_____

**Email Address:** _____

**Emergency Contact**:_____**Phone**:_____**Relationship**:_____

Employer`s Name:_____ Occupation:_____

Employer Address:_____

**Primary Insurance Name**:_____

Policy Holder`s Name:_____ SS#:_____ D.O.B:_____

ID #:_____Group #:_____ Relationship:_____

**Secondary Insurance**:_____

Policy Holder`s Name:_____ SS#:_____ D.O.B:_____

ID #:_____Group #:_____ Relationship:_____

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*If Applicable:* Auto Accident or Worker`s Comp. *(please circle)*

Employer : _____D.O.A:_____

Insurance Carrier: _____

Insurance Address: _____
**Street** **City** **State** **Zip**

Adjustor Name:_____ Phone Number:_____

CLAIM #:_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Paul M. Figlia MD, PA or insurance company to release any information required to process my claims.

_____

Patient/Guardian signature Date