Dr. Melissa Crosby
PLASTIC SURGERY

Patient Registration Form

Name: _____

Date: M M / D D / Y Y Y Y

PATIENT INFORMATION

Last Name	First	MI	Sex ❑ Male ❑ Female
Height	Weight	Bra Size	
Birth Date M M / D D / Y Y Y Y	Age	SSN - -	Drivers License
Address	City	State	Zip
Home Phone # ( ) -	Work # ( ) -	Cell # ( ) -	
Email		Preferred Method of Contact	
Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑ Domestic Partner			
Spouse's Name		Phone # ( ) -	
Emergency Contact Name		Phone # ( ) -	

INSURANCE INFORMATION

Primary Insurance	Policy #	Type of Network	Group #
Address	City	State	Zip
Insured's Name		Sex ❑ Male ❑ Female	
Insured's Employer		Phone # ( ) -	
Birth Date M M / D D / Y Y Y Y	SSN - -	Relationship to Patient ❑ Self ❑ Spouse ❑ Dependent	
Insurance Address	City	State	Zip
Person Responsible for Payment	Relationship to Patient	Phone # ( ) -	
Address	City	State	Zip

REFERRED BY

Physician	Magazine/Newspaper	Company
Friend	Health Fair/Community Event	Other
If you were refered by a specific person, may we thank them? ____ No ____ Yes		

I understand that office visit charges are payable on the day service is rendered. I authorize the physician to bill my insurance company for medically necessary services. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between the physician and myself.

Signature _____ Printed Name _____ Date _____

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PAST MEDICAL HISTORY

❑ Abdominal Bleeding	❑ Ear Infection	❑ Osteoporosis
❑ Anemia	❑ Epilepsy/Seizures	❑ Pacemaker
❑ Anxiety Disorder	❑ Facial Pain	❑ Peripheral Vascular Disease
❑ Arthritis	❑ Fever Blisters	❑ Pheumonia
❑ Asthma	❑ Hay Fever/Allergies	❑ Pulmonary Embolism
❑ Bleeding Disorder	❑ Headaches/Migraines	❑ Sinus Problems
❑ Breast Cancer	❑ Heart Attack	❑ Skin Cancer
❑ Bronchitis	❑ Heart Disease	❑ Skin Disease
❑ Cancer	❑ Heart Murmur	❑ Stroke
❑ Chest Pain/Tightness	❑ Hepatitis	❑ Thyroid Disease
❑ Coronary Artery Disease	❑ High Blood Pressure	❑ Tonsilitis
❑ Depression	❑ HIV/AIDS	❑ Tuberculosis
❑ Diabetes	❑ Hives	❑ Ulcers
❑ Dizziness/Vertigo	❑ Kidney Stones	❑ Other: _____

❑ No to all

ALLERGIES

Are you allergic to any medications? ❑ No ❑ Yes

Medication	Reaction
Medication	Reaction
Medication	Reaction

PREVIOUS SURGERY

Please list any surgeries or hospitalizations you have had in the past ❑ None

Surgery/Illness	Hospital	Year
Surgery/Illness	Hospital	Year
Surgery/Illness	Hospital	Year

CURRENT MEDICATIONS

Please list all current medications ❑ None

Medication	Dosage	Frequency	Reason	Prescribed
Medication	Dosage	Frequency	Reason	Prescribed
Medication	Dosage	Frequency	Reason	Prescribed
Medication	Dosage	Frequency	Reason	Prescribed
Medication	Dosage	Frequency	Reason	Prescribed

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SYMPTOMS

❑ Recent Weight Loss	❑ Chills	❑ Diarrhea
❑ Recent Weight Gain	❑ Rigors	❑ Chest Pain/Tightness
❑ Anxiety Disorder	❑ Nausea	❑ Shortness of Breath
❑ Fevers	❑ Vomiting	❑ Other: _____

❑ No to all

GENERAL INFO

Are You Pregnant? ❑ No ❑ Yes: _____ months	Number of pregnancies _____ Vaginal _____ C-Section	Number of children
Use of tobacco products ❑ Never ❑ In the Past ❑ Currently; _____ packs/day	Illicit Drug Use ❑ No ❑ Yes; Type(s):_____	
Alcohol Consumption ❑ Never ❑ Occasional ❑ Moderate ❑ Heavy _____drinks/week		

FAMILY HISTORY

Family Member	Health Issue	❑ Deceased
Family Member	Health Issue	❑ Deceased
Family Member	Health Issue	❑ Deceased

FINANCIAL RESPONSIBILITY

PLEASE READ CAREFULLY: YOUR INSURANCE CARRIER MIGHT NOT FULLY REIMBURSE YOU FOR HOSPITAL ADMISSION OR SURGICAL PROCEDURES.

I understand that payment in full is expected at the time services are rendered. If prior arrangements have been made, Dr. Melissa Crosby may bill my insurance company for the estimated portion. This is a courtesy to me and I am responsible for the total payment of all charges regardless of insurance coverage.

Since some insurance carriers are unnecessarily delaying payment of claims, I may be called upon for payment if Dr. Melissa Crosby has not received payment. If Dr. Melissa Crosby receives any subsequent payment from my insurance company, then a credit balance will be promptly refunded to me.

I understand that my insurance is a contract between me, my employer and the insurance company. Dr. Melissa Crosby is not a party to that contract and cannot be responsible for negotiating payment.

I hereby authorize my insurance benefits to be paid directly to Dr. Melissa Crosby realizing I am responsible for payment as stated above.

_____ _____

Signature Date