PINEHURST PLASTIC SURGERY SPECIALISTS, P.A.

Welcome to our practice. Please complete the following form so we may set up your patient record.
Thank You.

Patient Name: _____ Date: _____
(First) (Middle) (Last)

Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone No: (___) _____ Cell Phone No: (___)_____ Work Phone No: (___)_____

E-mail Address_____Permission to e-mail you regarding events and specials? ____yes ____no

Date of Birth: _____ Sex: _____ Marital Status: _____

Employer: _____ Occupation: _____

Employer Address: _____

In Case of Emergency, Notify: _____ Relation: _____

Home Phone No. (_____) _____ Work Telephone No. (_____) _____

Referring Doctor: _____ Family Doctor: _____

Person Responsible for Account: _____

Home Telephone No. (_____) _____ Work Telephone No. (_____) _____

Employer: _____ Occupation: _____

How did you hear about Dr. Zoellner?

Please indicate: Newspaper:___ Radio Station:___ Cable TV:___Yellow Pages:___Friend:___Family Member:___
Website: ___ Seminar: ___Pinestraw:____CityView:_____Internet Search:_____

PAYMENT IS EXPECTED AT TIME OF SERVICE

Method of Payment: Cash _____ Check _____ Credit/Debit Card _____ Care Credit _____

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS TO PINEHURST PLASTIC SURGERY SPECIALISTS, P.A.

I hereby authorize the physician designated to release information acquired in the course of my examination and treatment. I hereby assign payment directly to the designated physician for any medical/surgical procedures performed. I understand that I am responsible for any amounts not covered by insurance.

SIGNATURE: _____ DATE: _____
If patient is a minor or otherwise incapacitated, parent or guardian must sign form.