PINEHURST PLASTIC SURGERY SPECIALISTS

Welcome to our practice! Please complete the following forms so we can set up your patient record.
THANK YOU!!

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

Address: _____

City: _____ State: _____ Zip Code: _____

Permitted method of communication:

	Prefer Txt Msg	OK to leave Msg
CELL: _____	Yes or No	Yes or No
HOME: _____	NA	Yes or No
EMAIL: _____	Would you like contacted on events or specials? ___	

***Understand that Email is not a secure method of communication and that personal health information sent vial email may not be private.

Date of Birth: _____ Sex: Male or Female Marital Status: _____

Occupation: _____

Primary Care Physician: _____ Phone No: _____

In Case of Emergency, notify: _____ Relation: _____

Cell: _____ Work No: _____

How did you hear about Dr. Zoellner and Pinehurst Plastic Surgery Specialists?

Newspaper: ___ Radio Station: ___ Yellow Pages: ___ Website: ___ Internet Search:___Seminar:____

City View: ___ Self-Referral: ___ Friend or Family Member: ____ Name of Referral: _____

PAYMENT IS EXPECTED AT TIME OF SERVICE

We accept Cash, Certified Check, Debit, Visa, Mastercard, American Express, Discover and Care Credit

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AUTHORIZATION TO THE ABOVE FORMS OF COMMUNICATION AND TO PAY BENEFITS TO PINEHURST PLASTIC SURGERY SPECIALISTS

I certify that all the information is true to the best of my knowledge. I approve and acknowledge the above forms of communication from this office. If insurance is applicable, I hereby assign payment directly to Pinehurst Plastic Surgery Specialists for any medical/surgical procedures performed. I understand that I am responsible for any amounts not covered by insurance.

SIGNATURE: _____ DATE: _____

***If the patient is 17 years or younger, or otherwise incapacitated, the parent or guardian must sign this form. Please be sure to complete the emergency contact information.