RONALD M. FRIEDMAN, M.D., P.A.

Cosmetic and Reconstructive Plastic Surgery • Breast and Body Contouring

BOARD CERTIFIED, AMERICAN BOARD OF PLASTIC SURGERY

MEMBER OF THE AMERICAN SOCIETY OF PLASTIC SURGEONS

MEMBER OF THE AMERICAN SOCIETY FOR AESTHETIC PLASTIC SURGERY

New Patient Registration

Patient Name _____ Date of Birth ____/____/____
(Last) (First) (M.I.)

Home Address _____
(Street) (City) (State) (Zip)

Cell # ( ) _____ Alt # ( ) _____ Work # ( ) _____

E-Mail _____ *Please circle the best method to reach you.*

May we communicate medical information concerning your care to the CELL phone listed above? YES / NO *(Please circle)*

May we communicate medical information concerning your care to the EMAIL address listed above? YES / NO *(Please circle)*

SSN # _____ Driver's License # _____ State _____ Exp _____ Marital Status _____

Employer _____ Title _____ Phone ( ) _____
(Patient)

Address _____
(Street) (City) (State) (Zip)

Person to Notify in Case of Emergency _____ Relationship_____ Phone ( ) _____

May we communicate medical information concerning your care to the PERSON listed above? YES / NO *(Please circle)*

Primary Insurance Co. _____ Member # _____ Group #_____

Address_____ Benefits Phone ( ) _____ Pre-Cert Phone ( ) _____

Name of Insured _____ SSN #_____ DOB of Insured _____

If the Patient is a minor, the following information must be completed!

Parent or Legal Guardian _____ Relationship _____ SSN#_____

Address _____
(Street) (City) (State) (Zip)

Phone ( ) _____ Driver's License # _____ State _____ Exp _____

I hereby authorize **Ronald M. Friedman, M.D., P.A.** to furnish information to my insurance carrier concerning my illness and treatments, and I hereby assign to Dr. Friedman all payments for medical services rendered to myself or my dependents (unless Dr. Friedman has declined to accept assignment). I understand that I am responsible for any amount not covered by insurance. I understand that an explanation of benefits mailed to me by my insurer shall be considered notification of my responsibility to pay for the provided services. (A copy of this authorization shall be valid as the original.)
I understand and agree that regardless of my insurance status, I am ultimately responsible for my account balance for any professional services rendered.
I certify that the information on this form is true and correct to the best of my knowledge. I will notify your office of any changes.

Signature _____ Date _____

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