GERMAIN PLASTIC SURGERY

Timothy J. Germain, MD, FACS
Board Certified Plastic & Reconstructive Surgeon

Patient Registration

Patient Information

Name: _____Date of Birth: _____ Age: _____

First Middle Last

Home Address: _____

City State Zip

Home Phone: _____Work Phone: _____ Cell Phone: _____

Email Address: _____

Social Security #: _____Marital Status: __Single __Married __Divorced __Widowed

Employer: _____ Occupation: _____

Emergency Contact Person: _____ Phone: _____

Relationship to Patient: _____

Referred by: _____ Primary Care Physician: _____

Billing and Insurance Information

Primary Insurance Company Name: _____

Policyholder_____ Relationship to Patient: _____

If the Policyholder is **NOT** the Patient, complete the following:

Policyholder Name: _____ Date of Birth: _____

Relationship to Patient: _____ Employer: _____

Your insurance policy is a contract between you and your insurance company. The patient or guarantor is the person responsible for payment of all bills. You are responsible for knowing what services your insurance company will cover, your deductibles and your copayments. I, the undersigned certify that all the information above is correct and all insurance benefits are to be assigned directly to Dr. Timothy J. Germain. I understand I am responsible for all charges not covered by insurance. I hereby authorize the doctor to release all medical information necessary to secure payment of benefits. I hereby authorize the use of this signature on all insurance submissions.

Patient Signature: _____ Date : _____

Signature of Guarantor if Patient is under 18 years of age: _____