

**RENAISSANCE PLASTIC & RECONSTRUCTIVE SURGERY  
PATIENT DEMOGRAPHIC SHEET**

Patient Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Email address: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Spouse / Emergency contact information:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Relationship to pt: \_\_\_\_\_

**Referring Physician information: (Please give the name of the physician, not the practice name)**

Referring Physician Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

**Primary Care Physician information:**

Primary Care Physician Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

**IF YOU HAVE INSURANCE YOU WOULD LIKE US TO FILE, PLEASE PRESENT YOUR INSURANCE CARD AT CHECK-IN! PLEASE DO NOT PRESENT YOUR INSURANCE CARD IF YOU ARE PAYING OUT-OF-POCKET AND FILING YOURSELF!**

**PLEASE READ AND SIGN BELOW:**

I hereby assign payment directly to Renaissance Plastic and Reconstructive Surgery, P.A. for any medical / surgical procedures performed. I authorize release of information acquired in the course of my examination / treatment as outlined in the Privacy Policy of this practice. I agree to be responsible for payment of service determined by my insurance carrier as not medically necessary or non-covered service(s). I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. I also acknowledge that I have read / understand the Renaissance Plastic and Reconstructive Surgery, P.A. **“Notice of Privacy Practices for Protected Health Information.”** I hereby grant permission for the use of any record, illustration, photograph, or other imaging record created in my case, for use in examination, testing, credentialing, and/or certifying purposes by The American Board of Plastic Surgery, Inc.

\_\_\_\_\_  
**Patient signature (Parent / Guardian if patient is a minor)**

\_\_\_\_\_  
**Date**