

Richard P. Rizzuti, M.D.

J. Lynne Garrison, M.D.

Greenville Plastic Surgery, P.A. • 400 Spring Forest Rd. • Greenville, NC 27834 • (252) 758-6627 • FAX (252) 830-5138

PATIENT INFORMATION (Please Print - Complete in Black Ink)

Full Legal Name: (First Middle Last)						Chart #:	
Address:				City:		State:	Zip:
Age:	Birthdate:	Race:	Sex: M / F	Social Security #:			
Home Phone:		Cell Phone:		Work Phone:			
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed				Employer:			
Email Address:			Referred by:		Date of Injury:		
Patients Preferred Pharmacy				Pharmacy Location/City			
DRUG ALLERGIES:							
LATEX OR OTHER CONTACT ALLERGIES:				HISTORY OF TUBERCULOSIS? <input type="checkbox"/> Yes <input type="checkbox"/> No		DIABETIC? <input type="checkbox"/> Yes <input type="checkbox"/> No	
DO YOU TAKE BLOOD THINNERS? (inc., Aspirin, Any Supplements) <input type="checkbox"/> Yes <input type="checkbox"/> No							

PERMISSION TO RELEASE INFORMATION TO EMERGENCY CONTACT PERSON

I give Greenville Plastic Surgery permission to speak with the following individual(s) should they call regarding my care. I understand they will be considered my emergency contact.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

PERSON RESPONSIBLE FOR PAYMENT (If other than patient)

Name: _____ Relationship to Patient: Spouse Parents Other _____

Address: _____

Home Phone #: _____ Work Phone #: _____

HOW DID YOU HEAR ABOUT US?

- Family Member
 Friend
 Television
 Radio
 Internet/Website
 Google
 Bing
 Facebook
 Other _____
 Yahoo
 Yelp

INSURANCE INFORMATION - AREA TO BE COMPLETED WITH PRIMARY INSURED

PRIMARY INSURANCE POLICY

Insured's Name		SS#		DOB	
Insured's I.D. No. (include any letters)			Insured's Group No. (or group name)		
Insurance Co. Name					
Address for mailing claims		City		State	
				Zip	

ASSIGNMENT OF BENEFITS: I authorize my insurance company, attorney, or other party to pay directly to Greenville Plastic Surgery any medical expenses related to my care. I further authorize Richard P. Rizzuti, M.D., and/or J. Lynne Garrison, M.D. to furnish any information required to process insurance claims. I accept financial responsibility for any medical expenses incurred during my medical treatment and/or surgery. I hereby waive my right to privacy in matters of financial disputes with insurance companies, card holders or third party payers. A photocopy of this document shall be valid.

PRIVACY PRACTICES: I, the undersigned patient (or parent or guardian of a patient), have been made aware of the Privacy Practices of Greenville Plastic Surgery, P.A.

PHOTOGRAPHIC ILLUSTRATIONS: (This consent must be signed) I hereby give permission to Richard P. Rizzuti, M.D., and/or J. Lynne Garrison, M.D. to make any photographic or other illustrations of the above-named patient deemed advisable for diagnostic purposes and/or to enhance the medical record.

Signature

Date