GRAND STRAND PLASTIC & RECONSTRUCTIVE SURGERY CENTER (GSPRS)
4610 OLEANDER DRIVE, SUITE 101, MYRTLE BEACH, SC 29577 PHONE: (843-497-2227)

Prefix Mr. Mrs. Miss Ms. Dr. Preferred Name:

Patient's Name

First Middle Last

Address

Street & Apt # City State Zip

SS# Birthdate Age: Sex: ❑ Female ❑Male

Marital Status ❑ Single ❑ Married to: ❑ Other:

Home Phone Work Phone May we call you at work ❑ Yes ❑ No

Mobile Phone

Preferred Contact: ❑Home ❑ Work ❑Cell E-mail

Any restrictions for contacting you? ❑No ❑ Yes If yes, please describe

Emergency Contact: Relationship to Patient: Phone#:

Patient's Employer: Occupation:

Employer Phone: Employer Address:

Full Time Part Time Retired: Y N Student: Y N Other:

How did you hear about us? ❑ Friend ❑ Ad ❑ Internet ❑ Other Details:

Referring Dr.: Primary Care Dr.:

INSURANCE INFORMATION (Please bring card to appointment)

Primary Ins. ID # Group #

Insured: Name DOB SS#

Relationship to the insured? ❑Self ❑Child ❑Spouse ❑Other

Secondary Ins. ID # Group #

Insured: Name DOB SS#

Relationship to the insured? ❑Self ❑Child ❑Spouse ❑Other

INJURY/ACCIDENT INFORMATION

Injured at Work: Y N Auto Accident: Y N Other: Date of Injury:

Attorney Involved: Y N Name: Phone: Contact:

Preferred Pharmacy: Phone:

Street Name/City/St/Zip:

We feel that a liability action against someone else is not a reason to delay payment of your or this patient's account. Payment is the responsibility of the individual who received the service; not the person being sued. For this reason, and the fact that litigation may continue for an extended period, we feel our bill should be paid promptly. Should financial difficulties preclude prompt full payment, we urge you to contact our office to make appropriate arrangements to pay your or this patient's account. If subsequent payment is received as a result of litigation, or from any other source which results in a credit balance on this account, a full refund will be promptly paid to the appropriate party.

BILLING INFORMATION

Name of Person Financially Responsible for this account:_____

Relationship to Patient: _____DOB_____SS#_____

Address: _____Phone:_____

PRIVACY PRACTICES NOTICE AND WRITTEN ACKNOWLEDGEMENT FORM

I have been offered a copy of Grand Strand Plastic & Reconstructive Surgery Center's Noticy of Privacy Practices.

_____ *Date:* _____

(Signature of Patient/Guardian)

AUTHORIZATION OF PAYMENT & RELEASE OF INFORMATION

I request payment of authorized insurance benefits to be paid to GSPRS and authorize release of medical information as needed to determine payable benefits for services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

_____ *Date:* _____

(Signature of Patient/Guardian)