❑ 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: ❑ Single ❑ Married ❑ Legally Separated ❑ Divorced ❑ Widowed			Employer:		
Email Address:	Referred by:		Date of Injury:		

DRUG ALLERGIES:

LATEX OR OTHER CONTACT ALLERGIES: | HISTORY OF TUBERCULOSIS? ❑ Yes ❑ No | DIABETIC? ❑ Yes ❑ No

DO YOU TAKE BLOOD THINNERS? (inc., Aspirin, Any Supplements) ❑ Yes ❑ 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