PLASTIC & HAND
SURGICAL ASSOCIATES
Plastic, Reconstructive and Cosmetic Surgery
Surgery of the Hand
244 Western Avenue
South Portland, Maine 04106-2496
Telephone (207) 775-3446
Fax (207) 879-1646

Adult Registration Form

Please ✍ **in Black Pen**

Office Use: _____

❑ New ❑ Update ❑ New Problem

Today's Date ___/___/___

First Name Middle Last Mr./Mrs./Ms.				Social Security #	Home Phone ( ) Cell Phone ( ) e-mail address:
Date of Birth	Age	Marital Status	Name you would like us to call you (Optional)	❑ Female ❑ Male	
Mailing Address		City	State	Zip	
Residential Address		City	State	Zip	
Winter Address:				Phone:	
Employer	Occupation	Employer Address		Work Phone	Ext.
Spouse Name	Employer	Employer Address		Occupation	Work Phone
Person to contact in an Emergency WHO DOES NOT LIVE WITH YOU Name		Relationship	Address		Telephone
Family Doctor		Address			

We routinely send a copy of your office note to your family physician regarding your care. If we participate with your HMO, we are required to send a letter to your referring physician.

Are you being seen at the request of a medical provider: ❑ Yes ❑ No
If yes, please list Name and Address of that provider:

Why did you choose our practice?
❑ Employer ❑ Ins. Co. ❑ Friend/Relative ❑ Hospital ❑ Yellow Pages ❑ Seminar ❑ Website ❑ TV ❑ Attorney ❑ Health Fair ❑ Newspaper
❑ Other_____ Name of referring person (i.e. Hospital, Attorney, Friend): _____

Describe in your own words the reason for your visit, in detail.

Date of Injury or Onset of Problem Have you been treated for this prior to today ❑ Yes ❑ No If yes, Explain on next line

Where When Physician

Were X-rays taken? ❑ Yes ❑ No Where When

Please Complete your Insurance Information

What is your annual deductible? _____ **How much have you currently met?** _____

A. Insurance Company Name	Address	Policy Owner's Name & Date of Birth	Policy Certificate #	Group #
1. Primary				
2. Secondary				
3. Tertiary				

IS THIS A **WORKERS COMPENSATION** INJURY? DATE OF INJURY

Signature_____ **Date**_____