Renue
Plastic Surgery

New/Existing Patient Intake Form

Patient Registration Information		
Patient Name:	DOB:	Social Security #:
Race: ☐ Amer Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Decline to provide ☐ Other	Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to provide	Preferred Language (if not English): Gender: ☐ Male ☐ Female
Mailing Address: ; ,		
Home Ph:	Cell Ph:	Work Ph:
Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other		
Patient's Occupation:	Employer:	Employer Ph:
Would you like an email with the Patient Portal link? Y N	Email:	

Guarantor / Responsible Party		
Name:		Date of Birth:
Relationship to patient: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Family Member ☐ Other _____		
Mailing Address:		
Home Ph:	Cell Ph:	Work Ph:

Emergency Contact(s)	
Name:	Phone:
Relationship to patient: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Family Member ☐ Other _____	

Insurance	
PRIMARY INSURANCE:	**SECONDARY INSURANCE**:
Subscriber/Member ID #:	Subscriber/Member ID #:
Group #:	Group #:
Subscriber Name:	Subscriber Name:
Employer:	Employer:
Date of Birth:	Date of Birth:
Relationship to patient:	Relationship to patient:
Subscriber's SSN:	Subscriber's SSN:

I verify that I have reviewed the information above and have completed and/or corrected items where information was missing and/or incorrect. I attest that this information is accurate and complete to the best of my knowledge.

I hereby authorize payment of insurance benefits otherwise due to me to be made directly to Renue Plastic Surgery / Renue Surgery Center / Renue Surgery Center of Waycross. I understand that I am responsible for any amount not covered by the insurance company. A copy of this information shall be as valid as the original.

_____ _____

Patient / Legal Guardian Signature **Date**