The Plastic Surgery Group
Hayes Hand Center
Patient Information Form

MR#

D. Marshall Jemison, MD, Mark A. Brzezienski, MD J. Woody Kennedy, MD
Jason P. Rehm, MD Jimmy L. Waldrop, MD Todd E. Thurston, MD

Patient Name	Last	First	Middle
Date of Birth / /	Age		Sex ❑ Male ❑ Female
Social Security #			
Address			
City	State		Zip
Home Phone	Mobile		Work
Marital Status ❑ Married	❑ Single	❑ Divorced	❑ Separated ❑ Widowed
Race: ❑ American Indian ❑ Asian ❑ African American ❑ Caucasian ❑ Undefined			
Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unreported ❑ Refused to Report ❑ Undefined			
Language Preference			
Employer			
Spouse's Name	DOB		Social Security #
Spouse's Employer			Work Phone #
Emergency Contact		Relationship	
Emergency Contact Number			

DISCLOSURE OF PROTECTED HEALTH INFORMATION

According to office policy, test results or release of medical information including but not limited to, appointment times, lab or test results, etc. will be provided to the patient only. Please specify below whom information may be released to other than yourself. I grant permission for The Plastic Surgery Group, PC to release any and all of my medical information to the person(s) listed below.

Patient Signature:_____

Name	Relationship	Name	Relationship
Name	Relationship	Name	Relationship

May we leave messages at your: ❑ Home Answering Machine ❑ Cell Phone ❑ Work Voice Mail ❑ E-Mail

Email Address:_____

Preferred Notification Method: ❑ Mail ❑ Web Message

TPSG Communicates PHI to you through secure email. However, unless you have secure email on your media device, communications from you are over public wire. There should be no assumption of confidentiality when using email over public networks.

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PLEASE COMPLETE ALL SECTIONS

FINANCIAL INFORMATION

Person Responsible for Payment		Relationship to Patient
Address (if different from above)		
City	State	Zip
Home Phone	Work Phone	Mobile Phone

IF THE PATIENT IS A MINOR / STUDENT

Father's Name / Legal Guardian	Mother's Name / Legal Guardian
Address (if different from pt.)	Address (if different from pt.)
City State Zip	City State Zip
Social Security # - - DOB:	Social Security # - - DOB:
Work Phone #	Work Phone #
Home/Cell #	Home/Cell #
Employer	Employer

PLEASE PRESENT YOUR CURRENT INSURANCE CARD(S) TO OUR FRONT DESK

PRIMARY INSURANCE NAME:		Subscriber's Name
Relationship to pt.	DOB	SS #
SECONDARY INSURANCE NAME:		Subscriber's Name
Relationship to pt.	DOB	SS #

COMPLETE THIS SECTION IF YOU ARE COVERED UNDER MEDICARE

Medicare law requires that we determine if your medical services might be covered by another insurer. In order to assist us in the correct billing of these services, please answer the following questions.

Are you employed? ❑ Yes ❑ No	Is your spouse employed? ❑ Yes ❑ No
If Retired list date of Retirement / /	If Retired list date of Retirement / /
Please list employer information on front of form.	Please list employer information on front of form.
Please complete health plan information above.	Please complete health plan information above.

PLEASE COMPLETE THIS SECTION IF APPLICABLE

Are you eligible for coverage under Workers' Compensation/Job related? ❑ Yes ❑ No
Date of first symptoms or date or injury:
Is your injury / illness due to an accident? ❑ Yes ❑ No If yes, please complete the following: Name and address of auto insurance carrier: Name of Insured: Policy or ID # Accident Date: State where accident occured:

ADVANCED DIRECTIVES

Do you have a Living Will or Durable Power of Attorney? ❑ Yes ❑ No

Please provide The Plastic Surgery Group, P.C. with a copy for your file. The Plastic Surgery Group, P.C. does not honor Advanced Directives/Living Wills and our policy is as follows. Regardless of any advanced directive if an adverse event occurs during your treatment at this office, we will initiate resuscitative or other stabilizing measures and transfer you to the nearest hospital for further evaluation. At the hospital, further treatment or withdrawal of treatment measures already begun will be ordered in accordance with your wishes, Advance Directive, or Health Care Power of Attorney. Your agreement with this policy by your signature does not revoke or invalidate any current health care power of attorney.

_____

Signature of Patient or Responsible Party /Insured Date