SALMON CREEK
PLASTIC SURGERY

# PATIENT REGISTRATION FORM

**PATIENT INFORMATION:**

LAST NAME_____FIRST_____MI_____

DATE OF BIRTH_____/_____/_____ WEIGHT_____ HEIGHT_____ SEX: M_____ F_____ SSN_____

ADDRESS_____CITY _____STATE____ZIP_____

PREFERRED PHONE #_____ EMAIL_____

EMERGENCY CONTACT NAME AND PHONE_____

RACE_____ ETHNICITY_____ PREFERRED LANGUAGE_____

**PRIMARY CARE PHYSICIAN**_____ PHONE:_____

**REFERRING PHYSICIAN** _____PHONE:_____

**HOW DID YOU HEAR ABOUT US?**_____

FOR SPECIALS AND UPCOMING EVENTS "LIKE US ON FACE BOOK OR VISIT OUR WEBSITE AT
**WWW.SALMONCREEKPS.COM**

**RESPONSIBLE PARTY INFORMATION:** PATIENT_____PARENT/GUARDIAN_____ SPOUSE_____ OTHER_____

LAST NAME_____FIRST_____ DATE OF BIRTH____/____/____

ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____CELL_____WORK_____

**INSURANCE INFORMATION:** NAME OF INSURANCE_____EFFECTIVE DATE_____

SUBSCRIBER/NAME OF INSURED_____SS#_____

ID NUMBER_____GROUP #_____DATE OF BIRTH___/____/____

RELATIONSHIP TO PATIENT_____

SECONDARY INSURANCE NAME (IF APPLICABLE)_____EFFECTIVE DATE_____

NAME OF INSURED_____SS#_____RELATIONSHIP TO PATIENT_____

ID NUMBER_____ __GROUP NUMBER_____DATE OF BIRTH OF SUBSCRIBER_____/____/_____

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