SOUTHERN
INSTITUTE OF PLASTIC SURGERY

2800 Ross Clark Circle, Suite 2
Dothan, Alabama 36301
334-699-7477

Patient Information

Patient Name: ________________________________ Today's Date: __________________
Street Address: ________________________________ Apt, Lot, Ste #: ______________
City: __________________________________ State: ___________ Zip: __________
DOB: ___________ Race: _____ Age: _____ Sex: ____ Marital Status: ☐ M ☐ S ☐ D ☐ W
Home Phone #: _______________________ Cell Phone #: ________________________
Employer: ______________________________ Work #: ________________________
May we contact you at work? __________ Do you wish phone calls to be confidential? ________
Email: _______________________________ May we send information here? __________
SSN: ________________ How did you hear about our practice? __________________
Referring Physician (if applicable): ____
Primary Care Physician: ____

Emergency Contact Information

Contact Name: __________________________ Relationship to Patient: ______________
Contact Number: _____________________ Alternate number: _______________________

Insurance Information

Primary Insurance
Insurance Company: ______________________ Policy ID Number: __________________
Cardholder's Name: ______________________ Relationship to Patient: ______________
Cardholder's DOB: ______________________ Cardholder's SSN: __________________
Cardholder's Employer: ____

Secondary Insurance
Insurance Company: ______________________ Policy ID Number: __________________
Cardholder's Name: ______________________ Relationship to Patient: ______________
Cardholder's DOB: ______________________ Cardholder's SSN: __________________
Cardholder's Employer: ____

I authorize payment of benefits as determined by my insurance carrier directly to the physician. As the responsible party, I agree that I will be responsible for all charges incurred including those amounts not paid by my insurance company. Also, I agree that to my knowledge the above information is the most accurate and up to date. I authorize the release of this information as well as the release of medical records, if necessary, for payment by my insurance carrier. I authorize the use of this signature on all of my insurance submissions whether manual or electronic. I understand I will be charged for, and hereby agree to pay, all costs and expenses incurred in collection, any past due fees, and interest allowed by law, all without relief from valuation and appraisement laws.
Please note, there may be additional costs from outside laboratories. Biopsies, cultures, and other medical specimens will be sent to an outside lab. It is the patient's responsibility to contact their insurance carrier with inquires regarding network coverage for these facilities. Information on these facilities will gladly be supplied to the patient at their request.

Responsible Party Signature: ___________________________ Date: ______________