Center for Plastic & Cosmetic Surgery, Inc.
Gregory M. Fedele, M.D.

**Patient Registration Form**

Patient Name: _____ ___ Male __ Female
( Please Print) First Middle Last

Address: _____
Street

_____
City State Zip Code

Date of Birth: _____ Age: _____ Social Security Number: _____

Responsible Party: ___ Self ___ Other: _____ ( __ Parent __ Spouse )

Home Phone: ( ) _____ __ Single __ Married __ Divorced

Business Phone: ( ) _____ Spouse's Name: _____

Cellular Phone: ( ) _____ Spouse's Work Phone: _____

E-mail: _____ Family Doctor: _____
Full Name

If you are a student: __ Full Time __ Part Time _____
Address

Name of School: _____ _____
Phone Number

**Person to Contact in Case of Emergency:**

Who referred you? _____

Name: _____ __ Check here if same as family doctor

Relationship: _____ Pharmacy of Choice: _____

Home Phone: ( ) _____ Pharmacy Phone: ( ) _____

Business Phone: ( ) _____

I understand that photographs, digital, or other images may be recorded to document my care, and I consent to this. I understand that Center for Plastic & Cosmetic Surgery, Inc. will retain the ownership rights to these photographs, videotapes, digital, or other images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in Center for Plastic & Cosmetic Surgery, Inc's policy. Images that identify me will be released and/or used outside the institution only upon written authorization from me or my legal representative.

I, the undersigned, am aware that I am responsible for the payment of any co-pays and/or deductibles that may apply under my medical insurance contract. It is my responsibility to check with my insurance company to be sure that the physician is in my insurance network. I assume personal responsibility for any amount that insurance does not pay and deems payable by myself. I also agree to pay all fees if I have no insurance coverage. It is my responsibility to have a referral at the time of service. If I do not have a referral, I will pay all fees.

I, the undersigned, have received the Practice's notice of Privacy Practices and understand that my protected health information may be used by the Practice as described in the notice.

I authorize the release of any medical information necessary to process my claims, and payment of government benefits to the above mentioned office.

**Patient or Authorized Signature:** _____ **Date** _____