FERNANDO G. SERRA, M.D.
PATIENT REGISTRATION

DATE:_____ EMAIL ADDRESS:_____

SOCIAL SECURITY #_____-_____-_____ DATE OF BIRTH _____

FIRST NAME _____ GENDER: MALE / FEMALE

MIDDLE NAME/INITIAL _____ MARITAL STATUS: please check

LAST NAME _____ MARRIED_____SINGLE_____DIVORCED_____WIDOW_____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____

PREFERRED NUMBER TO CALL: HOME OR CELL

CIRCLE ONE: EMPLOYED RETIRED STUDENT OTHER

IF EMPLOYED, EMPLOYERS NAME _____

IF REFERRED, PHYSICIANS NAME _____

PHARMACY NAME _____ CITY _____

PHARMACY PHONE NUMBER _____

INSURANCE INFORMATION --- If this is a medical appointment, we will copy your insurance cards.

EMERGENCY CONTACT

NAME_____RELATIONSHIP_____

PHONE NUMBER _____

NOTICE OF PRIVACY PRACTICES: This is to certify that I have received a copy of the NOTICE OF PRIVACY PRACTICES, effective September 23, 2013, from Central Florida Plastic Surgery.

Patient signature_____Date_____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to Physician of the Surgical and/or Medical Benefits. If any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment to process insurance claims.

Signature_____Date_____