PLASTIC & HAND
SURGICAL ASSOCIATES
Plastic, Reconstructive and Cosmetic Surgery
Surgery of the Hand
244 Western Avenue
South Portland, Maine 04106-2496
Telephone (207) 775-3446
Fax (207) 879-1646

Child & Student Registration Form

Please ✍ **in Black Pen**

Office Use: _____

❑ New ❑ Update ❑ New Problem

Today's Date ___/___/___

First Name	Middle	Last	Age	Home Phone ( )
Date of Birth	Name you would like us to call you **(Optional)**		❑ Female ❑ Male	Cell Phone ( )
Mailing Address	City	State Zip		e-mail address:
Residential Address	City	State Zip		
Responsible Party		DOB	SS #	
Address		Home #	Cell #	
Occupation	Employer & Address		Work Phone	

Person to contact in an Emergency WHO DOES NOT LIVE WITH YOU
Name Relationship Address Telephone

Pharmacy Name Telephone

Family Doctor Address

We routinely send a copy of your office note to your family physician regarding your care. If we participate with your HMO, we are required to send a letter to your referring physician.

Are you being seen at the request of a medical provider: ❑ Yes ❑ No
If yes, please list Name and Address of that provider:

Why did you choose our practice?
❑ Employer ❑ Ins. Co. ❑ Friend/Relative ❑ Hospital ❑ Yellow Pages ❑ Seminar ❑ Website ❑ TV ❑ Attorney ❑ Health Fair ❑ Newspaper
❑ Other_____ Name of referring person (i.e. Hospital, Attorney, Friend): _____

Describe in your own words the reason for your visit, in detail.

Date of Injury or Onset of Problem Have you been treated for this prior to today ❑ Yes ❑ No If yes, Explain on next line

Where When Physician

Were X-rays taken? ❑ Yes ❑ No Where When

Please Complete your Insurance Information:
What is your annual deductible? _____ **How much have you currently met?** _____

A. Insurance Company Name	Address	Policy Owner's Name & Date of Birth	Policy Certificate #	Group #
1. Primary				
2. Secondary				
3. Tertiary				

Parent/Guardian Signature:_____ **Date:**_____