KONRAD L. DAWSON, MD

Washington Area Plastic Surgery Associates, PLLC

PATIENT REGISTRATION

Patient Name____ Birthdate________________ Age__________
(First) (Middle) (Last)

Social Security Number__________________________ Sex: Male _____ Female______ Marital Status____________________

Address____
Street City State Zip

Home Number______________________Work Number______________________Cell Number____________________

Email Address________________________

Are you ______Employed ______Student Occupation or Student Grade______________________________

Employer________________________________Address____

Emergency Contact Name____________________Relationship______________Phone Number________________

CONDITION INFORMATION

Reason for visit______________________________________Date of onset symptoms/accident________________

Work Related _____Yes_____No Auto Accident_____Yes_____No Other Accident____Yes_____No

PRIMARY INSURANCE

Insurance Company________________________ID/Policy#________________________Group#________________

Insurance Address____
Street City State Zip

Insurance Phone Number__________________________Provider Phone Number__________________________

Insured Name (If different from patient)__________________________________Birthdate________________

Insured Social Security#________________________ Sex: Male_____ Female_____ Relationship to patient ________________

Insured Address (If different from above) ____
Street City State Zip

Insured Home Number______________________________Work Number______________________________

SECONDARY INSURANCE

Insurance Company________________________ID/Policy#________________________Group#________________

Insurance Address____
Street City State Zip

Insurance Phone Number__________________________Provider Phone Number__________________________

Insured Name (If different from patient)__________________________________Birthdate________________

Insured Social Security#________________________ Sex: Male_____Female_____ Relationship to patient________________

Insured Address (If different from above____
Street City State Zip

Insured Home Number______________________________Work Number______________________________

INSURANCE AUTHORIZATION AND ASSIGNMENT

I certify that the above information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information to Dr. Konrad L. Dawson, MD and/or to my insurance carrier________________________to determine benefits payable for covered services rendered by the provider of services.

I authorize Dr. Konrad L. Dawson, MD to apply for benefits on my behalf from my insurance carrier listed above and request payments for covered services be made directly to Dr. Konrad L. Dawson, MD. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my carrier at any time in writing.

Signature____ Date________________________
(Insured or authorized person)