

To Our Patients:



Brevard Plastic Surgery &  
Skin Treatment Center  
Roxanne Guy, MD, F.A.C.S.

**Thank you** for choosing Brevard Plastic Surgery & Skin Treatment Center. Please take a few minutes to complete this information sheet. This will enable us to serve you more effectively. If you have any questions about any item on the form, please do not hesitate to ask.

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

First Middle Last

Marital status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Home Address:

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Birth-date: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer:

Employer's Address:

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

*Complete this section only if someone other than the patient is financially responsible.*

Responsible Party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Home Address:

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Birth-date: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer:

Employer's Address:

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Birth-date: \_\_\_\_\_ Age: \_\_\_\_\_

Home Address: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Birth-date: \_\_\_\_\_ Age: \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

**Insurance Information:**

Primary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

*NOTE: Please present insurance card to staff during registration process. Thank you!*

**Emergency Information:**

In case of emergency, contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

How did you learn about Dr. Guy? \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Name of individuals we leave messages with: \_\_\_\_\_

Can we mail information to your home?	Yes	No
Can we leave a message for you at home?	Yes	No
Can we leave a message for you at work?	Yes	No
Can we send e-mail to the address you provided?	Yes	No

**Release of Medical Information for Electronic Claim Filing:**

I authorize any physician, medical practitioner, hospital, clinic, or other medical or medically related facility, peer review organization, insurance or reinsuring company, the Healthcare Financing Administration, the Medical Information Bureau, Inc., consumer reporting agency, employer third party administrator having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and / or treatment of me or my dependents to give to the group policyholder, my employer third party administrator, my third party carrier or its legal representative, and all such information. I understand the information obtained by this authorization will be used to determine eligibility for benefits under my insurance coverage. Any information will not be released except to persons or organizations performing business or legal services in connection with the claim or claims submitted by Dr. Guy's office or Brickell Computer Systems, or as may be otherwise lawfully required or as I may further authorize. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_

**Payment of Benefits**

I authorize that payment of medical benefits be made to Brevard Plastic Surgery & Skin Treatment Center or physician listed on claim submitted for any services furnished me by that physician or organization, as agents for that physician or organization, as directed by the physician or organization.

I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_

**Release of Medical Records**

To Whom It May Concern: I hereby authorize you to furnish any and all medical information (including but not limited to: hospital records, reports, X-rays, charts and opinions) which are requested by my physician at Brevard Plastic Surgery & Skin Treatment Center; to said physician.

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_