

Advanced

Aesthetics, P.C.

PLASTIC SURGERY CENTER
www.plasticsurgerycorner.com

REGISTRATION FORM

- Edward S. Gronka, M.D., F.A.C.S.
- Paul D. Feldman, M.D., F.A.C.S., F.I.C.S.
- Joseph Raniere Jr., M.D., F.A.C.S.

Fayetteville Office
874 Lanier Ave. West, Suite 100
Fayetteville, GA 30214

Newnan Office
62 Hospital Rd.
Newnan, GA 30263

McDonough Office
50 Kelly Road, Ste. 100
McDonough, GA 30253

Rockdale Office
2800 Hwy 138 SW Suite D
Conyers, GA 30094

Please Print Clearly

1 PATIENT INFORMATION		2 SPOUSE OR RESPONSIBLE PARTY INFORMATION	
Last Name		Last Name	
First Name	M.I.	First Name	
Address		Address	
City	County	City	County
State	Zip	State	Zip
DOB	Gender: (Circle) M F	S.S. #	
Patient's SS#		Employer	
Home #	Work #	Occupation	Phone #
Cellular #		DOB	Gender: (Circle) M F
Patient's Occupation		Home #	Work #
Patient's Employer		Cellular #	
E-Mail Address		Relationship of Responsible Party to Patient	
Marital Status: (Circle One) Single Married Divorced Separated Widowed		3 EMERGENCY CONTACT (OTHER THAN SPOUSE)	
Ref Dr.	Primary Dr.	Name	
		Relationship	
		Phone #	

4 INSURANCE INFORMATION

Primary Ins	Secondary Ins
Last Name	Last Name
First Name	First Name
DOB	DOB
SS#	SS#
Patient Subscriber Relationship	Patient Subscriber Relationship
Insurance #	Insurance #
Plan/Group#	Plan/Group#

We ask all patients to show their insurance cards and drivers license so that we may make copies of them. We cannot render services on the assumption that our charges will be paid by an insurance company. All services are charged directly to the patient, and he or she remains personally responsible for payment. As a courtesy, however, we will file insurance claims to assist in making collections from insurance companies and will credit any such collection to the patients account.

AUTHORIZATION: I, _____, HEREBY AUTHORIZE DR. PAUL FELDMAN, DR. EDWARD GRONKA, DR. JOSEPH RANIERE AND DR. VIKISHA T. FRIPP TO RENDER CARE TO ME AS THEIR PATIENT. I ALSO AUTHORIZE THEM TO FURNISH INFORMATION CONCERNING MY PRESENT ILLNESS. I DIRECT THE INSURANCE COMPANY TO PAY, WITHOUT EQUIVOCATION, DIRECTLY TO THE PHYSICIAN, ALL BENEFITS DUE HIM AS A RESULT OF THIS CLAIM. ALTHOUGH COVERED BY INSURANCE, I AM AWARE THAT I AM PERSONALLY RESPONSIBLE FOR ALL CHARGES. A PHOTOSTATIC COPY OF THIS AUTHORIZATION WILL BE AS VALID AS THE ORIGINAL.

Patient Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____