Yoon Plastic Surgery, MD, LLC

Plastic, Reconstructive & Cosmetic Surgery

9715 Medical Center Drive, Suite 233, Rockville, MD, 20850. Phone 301-913-0304. FAX: 301-913-0306
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REGISTRATION FORM

Patient Information					
Title	First Name	M.I.	Last Name	Gender F / M	Social Security No.
Street			City	State	Zip Code
Home Phone	Cell Phone		Work Phone	Date of Birth	Age
Marital Status (please circle) Single Married Divorced Separated Widowed			Spouse Name (*If Applicable*)	Spouse phone number	
Patient Occupation	Employer		Employer Address	Employer phone number	
Emergency Contact			Relationship	Telephone Number	
Referred by (please specify)			**Primary Care Physician (PCP)**	**PCP Phone No.**	
Parent or Guardian (if patient is a minor)	***Address:***			***Telephone No.***	

Please Circle the Preferred Method of being Contacted: ***Cell Phone*** ***Home Phone*** ***Work Phone***

Insurance Information			
Primary Insurance		Insured Party Name	Social Security No.
Plan Name	Policy #	Date of Birth	Relationship to patient
Group Name	Group #	Insured's Employer	Employer Phone No.
Secondary Insurance		Insured Party Name	Social Security No.
Plan Name	Policy #	Date of Birth	Relationship to patient
Group Name	Group #	Insured's Employer	Employer Phone No.

Email Address: ____

PAYMENT OF BENEFITS / MEDICAL RELEASE AUTHORIZATION / RESPONSIBLE PARTY STATEMENT

I hereby authorize physician/group to diagnose and treat me or my dependents.
I, the undersigned, authorize payment of insurance benefits directly to Yoon Plastic Surgery, MD, LLC. I authorize Yoon Plastic Surgery, MD, LLC to release any information concerning my (or my child's) health care, advice and treatment provided to my insurance company, employer, third party payer, or third party payer administrators for purposes of evaluating and processing my claims. As the responsible party, I agree that I am responsible for payment of co-payments, co-insurance and/or deductibles in accordance with the terms and conditions of my health insurance policy. **I agree that in the event that my insurance company denies payment, if I have no insurance, or if services are not covered, that I am responsible for the balance due on my account.**

I acknowledge and agree to all of the above information.

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Patient Signature (or parent if minor) ***Date*** ***Witness***

*** A photocopy of your insurance card and photo ID are required ***