BARRY PRESS, M.D.
PATIENT REGISTRATION

Name:	**Date of birth:**	**Today's date:**
Address:	Sex: ☐ male ☐ female	
	Marital status: Married	
City/State/Zip:	Occupation:	
Home phone:	Employer:	
Work phone:	Business address:	
Cell phone:		
Social security number:	**Email address*:**	
Do you wish to receive email on plastic surgery topics: ☐ YES ☐ NO		
Would you like to access your health record electronically? ☐ YES ☐ NO →	*If you checked **YES**, you will receive an email from our office with instructions on connecting to your current health record with diagnoses and medications. If any information is incorrect, please notify our office immediately.	
CA drivers license no:		
Referred by:		
Primary physician name:	**Pharmacy preference:**	
Address:	**Address:**	
Relative/friend NOT living with you: **Name:**	**Relationship:**	
Address	**Phone:**	
What are you seeing the doctor for today?:		
Is this a work injury?: ☐ YES ☐ NO	Date of injury:	

PRIMARY INSURANCE	SECONDARY INSURANCE
Name:	Name:
Address:	Address:
Subscriber:	Subscriber:
Rel. to patient:	Rel. to patient:
Subscriber's date of birth:	Subscriber's date of birth:
Group or policy no.:	Group or policy no.:
Certificate or ID no.:	Certificate or ID no:

ASSIGNMENT OF BENEFITS

I authorize Barry Press, M.D, to release to my insurance company any and all information that might be required to evaluate my claim (or potential claim) for insurance benefits pertaining to myself and/or my dependent. I authorize my insurance carrier to pay, and hereby assign payment to the above named physician, any and all benefits otherwise payable to me for his services. I understand that I am financially responsible for all charges over and above those benefits that may be paid directly to the above named physician. A copy of this assignment shall be as valid as the original.

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AUTHORIZED SIGNATURE **DATE**