

Capitol Plastic Surgery
Salman Ashruf, M.D.
Board Certified Plastic and Hand Surgeon
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REGISTRATION FORM

PATIENT NO.	Failure to complete all spaces on the form will result in delays. If a section does not apply to you, write "N/A"	DATE:
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PATIENT NAME: LAST	FIRST	M	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE
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BIRTH DATE:	AGE:	SSN:	HOME PHONE:
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STREET ADDRESS:	CITY:	STATE:	ZIP:
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ADDITIONAL CONTACT INFORMATION - CELL PHONE NUMBER:	E-MAIL ADDRESS:
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PATIENT'S EMPLOYER:	ADDRESS:	WORK PHONE:
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IS YOUR VISIT DUE TO:		} HAVE YOU FILED A CLAIM? <input type="checkbox"/> YES <input type="checkbox"/> NO
1. A WORK RELATED CONDITION: <input type="checkbox"/> YES <input type="checkbox"/> NO	2. AN AUTOMOBILE ACCIDENT: <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES, COMPLETE SECTION "PIP" BELOW)	
3. A LIABILITY CASE: <input type="checkbox"/> YES <input type="checkbox"/> NO		

ATTORNEY:	ADDRESS:	PHONE:
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WORKER'S COMPENSATION INFORMATION

NAME OF EMPLOYER AT TIME OF CLAIM:	ADDRESS:	PHONE:
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NAME OF COMPENSATION INSURANCE COMPANY:	ADDRESS:	PHONE:
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ADJUSTER'S NAME:	CLAIM NO.:	DATE OF ACCIDENT/ONSET OF CONDITION:
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INSURANCE INFORMATION

PIP (PERSONAL INJURY PROTECTION) INSURANCE (COMPLETE ONLY IF IN AUTO ACCIDENT)

NAME OF AUTOMOBILE INSURANCE:	ADDRESS:	PHONE:
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INSURED'S NAME:	ADJUSTER'S NAME:
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CLAIM NO.:	DATE OF ACCIDENT:	STATE WHERE ACCIDENT OCCURRED:
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PRIMARY HEALTH INSURANCE (CAREFIRST, MEDICARE, HMO's, ETC.)

NAME OF INSURANCE COMPANY:	ADDRESS:
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POLICYHOLDER NAME:	POLICY HOLDER'S DATE OF BIRTH:	RELATIONSHIP TO PATIENT:
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POLICYHOLDER'S SOCIAL SECURITY NO.:	POLICY NO.:	GROUP NO.:	POLICY HOLDER'S EMPLOYER:
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SECONDARY HEALTH INSURANCE (CAREFIRST, MEDICARE, HMO's, ETC.)

NAME OF INSURANCE COMPANY:	ADDRESS:
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POLICYHOLDER NAME:	POLICY HOLDER'S DATE OF BIRTH:	RELATIONSHIP TO PATIENT:
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POLICYHOLDER'S SOCIAL SECURITY NO.:	POLICY NO.:	GROUP NO.:	POLICY HOLDER'S EMPLOYER:
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OFFICE USE ONLY	CO-PAY:	REFERRAL NEEDED: <input type="checkbox"/> YES <input type="checkbox"/> NO
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