REGISTRATION
(Please Print)

SMITH PLASTIC SURGERY

BRENDAN E. SMITH, M.D.
16 OKATIE CENTER BLVD. SOUTH, SUITE 101
OKATIE, SC 29909
843-705-8940

DATE: _____ **HOME PHONE:** (____)_____ **CELL #**(____)_____

PATIENT INFORMATION

Name: _____ Soc. Sec #_____
Last Name First Name Initial
Address: _____
City: _____ State: _____ Zip: _____
Sex: M F Age: _____ Birthdate: _____ E Mail: _____
Marital Status (**Circle**): Single Married Widowed Separated Divorced
Patient Employed By: _____ Occupation: _____
Business Address: _____
City: _____ State: _____ Zip: _____
Business Phone: (_____)_____
Were you injured on the job (**Circle**)? Yes or No Were you injured in an auto accident (**Circle**)? Yes or No
Date you were injured? : _____
How did you get the name of our office? _____
EMERGENCY CONTACT: _____ Relationship: _____ Phone:(____)_____

PRIMARY INSURANCE

Primary Insurance Subscriber: _____
Last Name First Name Initial
Relation to Patient: _____ Birth date: _____ Soc Sec #: _____
Address (If different from patient's): _____ Phone:(____)_____
City: _____ State: _____ Zip: _____
Person Responsible Employed By: _____ Occupation: _____
Business Address: _____ Phone: (____)_____
Insurance Company: _____ Subscriber #: _____
Contract #: _____ Group #: _____

ADDITIONAL INSURANCE

Is the patient covered by additional insurance? Yes No
Subscriber Name: _____ Relation to Patient_____ Birth Date: _____
Address (If different from patients): _____ Phone (____)_____
City: _____ State: _____ Zip: _____
Insurance Company: _____ Subscriber #: _____
Contract #: _____ Group #: _____

I hereby authorize the release of medical record information to my insurance company, its assigns, representatives, or any physician or medical facility providing medical care. I also authorize my insurance company to pay any benefits payable under my policy to Smith Plastic Surgery. By signing below I acknowledge that I am financially responsible for all charges incurred whether or not paid by my insurance company.

_____ _____
PATIENT SIGNATURE _____ DATE _____

_____
RELATIONSHIP TO PATIENT

REV 02/05/2019

FINANCIAL POLICY OF SMITH PLASTIC SURGERY

Smith Plastic Surgery is committed to providing you the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask us if you have any questions about our fees, financial policy, or your responsibility.

Full payment is expected at the time the service is rendered. If you have health care coverage through a plan with which the physician participates all patient deductibles, co-payments, coinsurance and/or non-covered services are due at the time of service. **Co-payments or outstanding balances are to be paid at the time of check-in. If your co-payment or outstanding balance cannot be paid at the time of your visit, your appointment will need to be rescheduled.**

If surgery is recommended, you must pay any deductible and/or co-payment, which have not been satisfied at the time your surgery is scheduled. If you do not have insurance coverage, you will be required to pay for your procedure in full prior to your procedure being performed.

As our services are provided to you, not your insurance company, payment for service is your responsibility. Therefore, all charges that are filed to your insurance carrier and are not paid within 60 days from the date of filing become your responsibility.

If you have been involved in an automobile accident or have suffered an injury, please know that we **DO NOT GET INVOLVED IN ANY THIRD PARTY LITIGATION**. Dr. Smith's services were provided to you and payment is due from you.

Cosmetic surgeries/procedures and injections are to be paid at the time services are rendered or earlier depending on the type of treatment and date of the treatment. Please refer to your cosmetic "cash" quote when it is provided to you as to when payment is due. If you are having a cosmetic surgery, a $500.00 deposit is required at the time of scheduling your procedure. This deposit is applied to your total surgery cost and is **non-refundable** if you cancel your surgery or reschedule beyond 60 days from your original surgery date. The entire balance is due 14 days prior to your actual surgery date.

All new patients are asked to complete our "Patient Registration and HIPAA Forms" prior to seeing the physician. We request our established patients inform us of any changes in his/her name, address, telephone number, employer and/or insurance status or medications being taken. We will verify this information with you at each visit. You will be asked to complete a new registration annually.

Please verify your insurance coverage and bring your insurance card(s) to our office each time you visit.

A $145.00 no show fee will be assessed to you for failing to cancel your appointment within 2 business days prior to your scheduled appointment. A returned check fee of $35.00 will be assessed to you for any returned checks.

If it becomes necessary for your account to be placed in collections due to nonpayment, the patient and/or guarantor are responsible for all associated collection costs in addition to the outstanding balance due to owed to our practice.

Smith Plastic Surgery accepts cash, checks (certified or cashier's checks for surgeries), MasterCard/Visa, and American Express as payment for services rendered. We do accept financing through a company called Cherry. If you need to obtain financial assistance for a non-insurance procedure, **you must notify us at the time of your appointment prior to scheduling any procedure**.

Thank you for understanding our Financial Policy. We appreciate your compliance with this policy. Please let us know if you have any questions or concerns regarding this policy.

Patient/Guarantor Signature_____ Date: _____

Relationship to Patient_____ Date: _____

Witness _____ Date: _____

REV 02/1/2025

"Reason for your office visit today":_____

YOUR HEALTH HISTORY

Please circle Y or N if you have or have had any of the following conditions

Anemia	Y	N	Glaucoma	Y	N	Mitral Valve Prolapse	Y	N
Anxiety/Depression	Y	N	Heart Attack Year_____	Y	N	Pneumonia	Y	N
Arthritis	Y	N	Heart Conditions/Disease	Y	N	Psychiatric / Emotional	Y	N
Asthma	Y	N	High Blood Pressure	Y	N	Rheumatic Fever	Y	N
Auto Immune Disorder	Y	N	HIV/AIDS	Y	N	Stroke	Y	N
Bleeding Disorders	Y	N	Hives/Eczema	Y	N	Thyroid Disease	Y	N
Breathing/Lung Issues	Y	N	Hepatitis	Y	N	Ulcer	Y	N
Cancer	Y	N	Intestinal Disorder	Y	N	Venereal Disease	Y	N
Diabetes Type____	Y	N	Kidney Disease	Y	N			
Epilepsy	Y	N	Liver Disease	Y	N			

If you answered YES to any of the above questions please explain:_____

_____

Please list any other disease/condition/chronic illness not listed above:_____

_____

Please list **ALL** allergies (Medication, Food, Environmental):_____

Please list **ALL medications** you are currently taking **including non-prescription** medications or **weight loss** medications:_____

_____

_____

Have you ever been hospitalized or undergone any type of surgery? Please list:_____

_____

_____

Have you ever had any type of reaction to anesthesia (local, general, conscious sedation)? _____

Do you have any special needs that we need to be aware of? _____

Primary Care Physician:_____ Phone:_____

Height:_____ Weight:_____ History of Smoking/Vaping: (Y) (N) _____ per day, Year Quit: _____
Alcohol:_____ Caffeine:_____ Recreational Drugs:_____

Family History

Does any **parent, sibling, grandparent or your children** have or had any of the following (**circle Y or N**):

			Relationship to you				Relationship to you
Cancer	Y	N		Stroke	Y	N	
Diabetes	Y	N		Epilepsy	Y	N	
Heart Disease	Y	N		Anemia	Y	N	
High Blood Pressure	Y	N		Bleeding Disorder	Y	N	

Patient Signature:_____ Date:_____
Preferred Pharmacy & Phone #: _____