O'Sullivan Plastic Surgery, P.C.
Cosmetic & Reconstructive Surgeons

PATIENT REGRISTRATION: Today's Date: _____

Preferred Title (please circle): Mr. ☐ Ms. ☐ Mrs. ☐ Miss ☐ Dr. ☐

Patient's First Name_____ Middle Initial____ Last Name:_____

Date of Birth: __/__/____ Patient's SS#: ___-__-____ Gaurantor's SS#: ___-__-_____

Home Address:_____ City_____ State:_____ Zip: _____

Home Phone: 1(___)___-____ Cell Phone: 1(___)___-____

Work Phone: 1(___)___-____ Relative/Friend's Phone: 1(___)___-____

Pharmacy Phone: 1(___)___-____

Please select where messages can be left:

Home: ☐ Office: ☐ Cellular: ☐ None: ☐

E-mail Address: _____

Is email ok for surgical confirmation?: Yes ○ No ○

Patient's Occupation: _____

Employer: _____ Contact: _____

Employment Address: _____ Tel: 1(___) ___-____

Marital Status: Single: ☐ Married: ☐ Divorced: ☐ Widowed: ☐

Please name the person to contact in emergency: _____

Home Phone: 1(___) ___-____ Work Phone: 1(___) ___-____

Cell Phone: 1(___) ___-____

Relationship to patient: (Check):

Spouse: ☐ Parent: ☐ Sibling: ☐ Friend / Guardian: ☐

The “Guarantor” Insurance Policy Holder / person paying bill:

Relationship to patient: _____

Gaurantor’s Last Name_____ First Name, MI _____

Date of Birth: __/__/____

Social Security # __-__-____ Home Tel #: 1(___)___-____ Work Tel#: 1(___)___-____

Address_____ City_____ State:_____ Zip: _____

Employer: _____ Tel #: 1(___)___-____ Supervisor: _____

How did you find out about Dr. O’Sullivan:

Internet: ☐ If Internet, which site: _____

Verizon: ☐ Yellow book: ☐ Insurance: ☐

Friend: ☐ If friend, what was their name: _____

Doctor: ☐

Doctor who referred you:

Name:_____ Tel #: 1(___)___-____
Address_____ City:_____ State:_____ Zip _____

Primary Care MD: Name:_____ Tel #: 1(___)___-____
Address:_____ City:_____ State:___ Zip_____

Please name other Doctors you go to:_____ Tel #: 1(___)___-____
Address:_____ City:_____ State:___ Zip_____

Primary Insurance Company: _____

Type: HMO: ☐ PPO: ☐ Unrestricted: ☐ Auto: ☐ Litigation: ☐ Self pay: ☐

Policy Holder’s full name:_____ _____ Copay:_____
Certificate #:_____
Address:_____ City:_____ State:___ Zip_____
Tel #: 1(___)___-____ Code:_____
Payor/ Group:_____

Referral Needed?: Yes ○ No ○

If yes please have your primary care physician fax: 781-235-0006 a referral to our office.

You will need to provide the following information to your Physician:

Dr. Kimberley O'Sullivan:

Office# 781-235-1007, Fax# 781-235-0006
NPI# 176_461917

Dr. Renee O'Sullivan:

Office# 781-235-1007, Fax# 781-235-0006
NPI# 1942289194

Secondary Insurance Company: _____

Type: HMO: ☐ PPO: ☐ Unrestricted: ☐ Auto: ☐ Litigation: ☐ Self pay: ☐

Policy Holder's full name:_____
Copay:_____ Certificate #:_____ Code:_____
Payor/ Group:_____
Address:_____ City:_____ State:___ Zip_____
Tel #: 1(___)___-____ Other info on Card_____

Date 1st seen By the Dr. :_____

Place First Seen By the Dr. (Check):

Office: ☐ ER: ☐ Hospital: ☐ Other: ☐

If Other, please specify: _____

Describe the injury / reason for visit:

Height:_____ Weight: _____

Last Tetanus shot:

1 Year: ☐ 1-2 Years: ☐ 2-5 Years: ☐ 5-10 Years: ☐ 10 or More Years: ☐

What are your medication Allergies:

Do you have a latex Allergy? Yes ○ No ○

What & how much do you Smoke? :

Do you use anticoagulants? Yes ○ No ○ Don't know ○

Are you Diabetic? Yes ○ No ○

Are you being treated for high blood pressure? Yes ○ No ○

Do you have Sleep Apnea? Yes ○ No ○

Are you a carrier of the following infectious agents:

MRSA: Yes ○ No ○ VRE: Yes ○ No ○ TB: Yes ○ No ○

MOTOR VEHICLE ACCIDENT: The claim will be billed to both the Auto & Health

Insurance Companies:

Owner of the car's Name: _____ Date of Birth:__/__/____
Your Car Insurance Company Name: _____ Tel #: 1(___)___-____
Car Insurance Address:_____ City:_____ State:___ Zip: _____
Car Ins. Policy #_____ Claim #_____ Contact Person_____

Offendant's Insurance Company_____ Representative_____
Address_____Tel #: 1(___)___-____Fax: 1(___)___-____Claim#_____

Worker's Compensation Case, please also list:

Work Contact Person_____ Tel #: 1(___)___-____Fax: 1(___)___-____
Claim #_____
Worker's Comp Insurance Company: _____ Tel #: 1(___)___-____
Worker's Comp Contact Person:_____ Tel #: 1(___)___-____

Your Lawyer's Information:

Lawyer's Name:_____ Company: _____
Address:_____ City:_____ State:___ Zip_____

Tel #: 1(___)___-____Fax: 1(___)___-____

File#_____

Financial Agreement / Waiver: I authorize release of any medical records necessary to process any insurance claims and I authorize payment of medical benefits directly to the physician or supplier of services for myself and/or dependents. I understand that I am responsible for any deductibles, coinsurance's or amount for services not covered by the insurance carrier. I understand if I do not obtain a referral for each treatment I will be responsible for the cost of all services, that the late payments are subject to 2_%interest and will result in the loss of any discounts offered a the time surgical booking; that there will be a $5_.__ fee for returned checks.; and that I will be responsible for all fees, postage and telephone charges, billing fees , etc. related to the need to collect late fees through the billing company or collection agencies. I agree use of my photos for teaching purposes or, on the web , as demonstration for the principles of plastic surgery and examples of pre and postoperative result. $15.__ collection fee will be added to any copay not paid at the time of the visit. I acknowledge that I have received O'Sullivan Plastic Surgery's Notice of Privacy Practices.

Please sign:_____ Date:_____

Submit by Email | Print Form