Nicole Schrader, M.D., F.A.C.S.
Schrader Plastic Surgery
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PATIENT REGISTRATION FORM

Please print. All items MUST be filled out. ****Please give all insurance cards to receptionist.****

Patient Name: ____ Male__________ Female____________

Home Address: ____

City: _______________________ State: _______ Zip: _________ Home Telephone: ____________________

Patient's SS#_______________________________ **Patient's Birthday:** ______________________________

Cell: ______________________________ **Email Address**: ____

Referred by: ______________________ Referring Physician: _______________________________________

Responsible party for patient: ___________________________ Relationship: __________________________

Emergency Contact: _______________________________ Telephone: ______________________________

Primary Insurance: ___________________________________ Address: ______________________________

Subscriber/Policyholder: ___________________________ **Subscriber SS#:**_____________________________

Subscriber Date of Birth: _______________________ Relationship to Patient: ________________________

Home address: _______________________________________Employer:_____________________________

Telephone: _________________________________ Cell: ____

Patient agrees & acknowledges that he/ she is responsible for all attorney fees and costs incurred by Facial Plastic & Reconstructive Surgery, LLC should any type of legal action be required to collect any unpaid balances by patient and/ or the retention of an attorney by Facial Plastic & Reconstructive Surgery, LLC be required.

I authorize Nicole Schrader, MD to furnish information to my insurance carrier(s) concerning my illness(es) and treatment. I hereby assign all insurance payments to Nicole Schrader, MD C/O Facial Plastic & Reconstructive Surgery, LLC and agree to accept full responsibility for all charges for medical services provided to myself and/or any dependents that may not be covered by insurance. **WITHOUT EXCEPTION**, any charges for any medical services that are not covered by insurance are the full responsibility of the patient, or the responsible party who has signed for this patient.

SIGNATURE: ____ Date: _______________________________

(If patient is a minor, relationship of person signed) ____