Allison M. Holzapfel, MD., F.A.C.S.
Allison E. Lied, M.D.

Holzapfel & Lied Plastic Surgery

Patient Registration

Patient Name: _____
First Middle Initial Last

Address	Apt #	City	State	Zip
Home Phone	Cell Phone	Email Address		
Date of Birth	Social Security #	Sex M F Marital Status M S D W S Sep		
List all allergies (drug, food, latex)				
Employer	Occupation	Phone #		
Address	City	State	Zip	

Responsible Party Information

Name: _____
First Middle Initial Last

Address	Apt #	City	State	Zip
Home Phone	Cell Phone	Social Security #		
Employer	Occupation	Phone #		
Address	City	State	Zip	

Emergency Contact Information

Name	Relationship
Home Phone	Cell Phone

Insurance Information

Primary Carrier	Subscriber Name	Subscriber DOB
Address	Phone #	
Policy #	Group #	
Secondary Carrier	Subscriber Name	
Address	Phone #	
Policy #	Group #	

Patient's or Authorized Person's Signature

I hereby assign medical and/or surgical benefits to include major medical benefits to which I am entitled including, Medicare, private insurance and other health plans to: Holzapfel & Lied Plastic Surgery.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee release all necessary information to secure payment.

Signature of patient / parent / authorized person _____ Date: _____