

**BRUCE K. BARACH, M.D.**  
**Patient Registration**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone Number \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Marital Status (circle) SGL MARRIED DIV CHILD  
Referring Source/M.D. \_\_\_\_\_ Primary Doctor \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer Address \_\_\_\_\_ Work Phone Number \_\_\_\_\_ Extension \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Relation \_\_\_\_\_  
Reason for Visit \_\_\_\_\_

**SPOUSE INFORMATION**

Spouse's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Soc. Sec. Number \_\_\_\_\_  
Spouse's Employer \_\_\_\_\_ Work Phone Number \_\_\_\_\_ Extension \_\_\_\_\_

**PARENT INFORMATION**  
**(if patient is a child)**

Father's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Soc. Sec. Number \_\_\_\_\_  
Father's Employer \_\_\_\_\_ Work Phone Number \_\_\_\_\_ Extension \_\_\_\_\_  
Mother's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Soc. Sec. Number \_\_\_\_\_  
Mother's Employer \_\_\_\_\_ Work Phone Number \_\_\_\_\_ Extension \_\_\_\_\_

**MEDICAL INSURANCE**

Primary Insurance \_\_\_\_\_ Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_  
Address \_\_\_\_\_ Copay \$ \_\_\_\_\_ Policyholder \_\_\_\_\_  
Secondary Insurance \_\_\_\_\_ Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_  
Address \_\_\_\_\_ Copay \$ \_\_\_\_\_ Policyholder \_\_\_\_\_  
Is this a Worker's Comp Injury? Yes No Date of Injury \_\_\_\_\_  
Is this a No-Fault Injury? Yes No Date of Accident \_\_\_\_\_  
Name of Vehicle Owner \_\_\_\_\_ Place of Accident \_\_\_\_\_

**INSURANCE AUTHORIZATION AND ASSIGNMENT AND PHOTO CONSENT**

I hereby authorize Upstate Plastic Surgery, P.C. to furnish information to ?? insurance carriers concerning my diagnosis and treatments. I hereby assign to Upstate Plastic Surgery, P.C. all payments for services rendered to myself for my dependents. I understand that I am responsible for any amount not covered under the terms of ?? insurance contract and that 1.5% interest will accrue on balances over 60 days. Further, I understand that failure to remit payment as per this assignment will result in collection proceedings, and that I will be responsible for all collection ?? and/or attorney fees associated with such action. I also consent to pre- and post-operative photos which shall conceal my identity, to be used for professional and patient education, as well as surgeon workshops and seminars, and in certain medical and marketing materials.

Signature of Patient or Responsible Party \_\_\_\_\_