Parker Plastic Surgery
James A. Parker, M.D.
1181 Langford Drive, Bldg 300-105
Watkinsville, GA 30677
P: 706.543.0404 | F: 706.549.0065

Patient Information

First Name:_____ MI:_____ Last:_____

Nickname:_____ Former Name:_____

DOB:_____ Age: _____ Gender: F M SSN:_____

How did you hear about Dr. Parker? ☐ Google ☐ Facebook ☐ Other:_____

☐ Patient Referral: _____ ☐ Friend/Family:_____ ☐ Dr. Referral:_____

Home Address:_____ Apt. _____

City:_____ State:_____ Zip:_____

Home Ph:_____ Cell Ph:_____ Cell Carrier:_____

Email address:_____

Employer:_____ Address:_____

Occupation:_____ Work Phone:_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Responsible Party *(if patient is under 18 years old)*

Relationship:_____

Last Name:_____ First Name:_____ MI:_____

Address:_____ Apt. #_____

City:_____ State:_____ Zip:_____

Home Ph:_____ Work Ph:_____ Cell Ph:_____

Emergency Contact

Relationship:_____

Last Name:_____ First Name:_____ MI:_____

Address:_____ Apt. #_____

City:_____ State:_____ Zip:_____

Home Ph:_____ Work Ph:_____ Cell Ph:_____

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Insurance Information

Primary Ins. Co:_____

Ins. Address:_____

Insured's Name:_____

Insured's DOB:_____ Insured's SSN:_____

Policy:_____ Group:_____

Secondary Ins. Co:_____

Ins. Address:_____

Insured's Name:_____

Insured's DOB:_____ Insured's SSN:_____

Policy:_____ Group:_____

Assignment and Release

I have insurance coverage and assign all medical benefits, if any, otherwise payable to me for services rendered. I understand that it is my responsibility to verify that Dr. Parker is a participating provider with my insurance plan and that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Dr. Parker to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured/Guardian Date