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