GODWIN PLASTIC SURGERY

Dr. Kenneth A. Godwin, DO
Board-Certified Plastic & Reconstructive Surgeon
301 Oxford Valley Road, Suite 903, Yardley, PA 19067
267-399-9930 • godwinplasticsurgery.com

Patient Registration

Personal Information

First Name: _____ Middle: _____ Last Name: _____

Preferred Name (if different): _____ Preferred Pronouns: _____

Date of Birth: _____ Age: _____ Sex: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Other Phone: _____

Email: _____

May we leave a voicemail regarding appointments at these numbers? ☐ **Yes** ☐ **No**

May we send text appointment reminders? ☐ **Yes** ☐ **No**

Emergency Contact

Name: _____ Relationship: _____

Phone: _____

Parent / Guardian Information

(To be completed only if the patient is under 18 years of age)

Name: _____ Relationship: _____ Phone: _____

Your Visit

Reason for your visit today: _____

How were you referred to our office? _____

Medicare Information *(applies only if you have Medicare — otherwise, leave blank)*

Godwin Plastic Surgery participates with Medicare only. We do not bill secondary or supplemental insurance of any kind. You are responsible for any portion of charges not covered by Medicare.

I have read and understand the above. Initials: _____

_____
Signature of Patient (or Parent/Guardian) Date

_____
Print Name

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Patient Release & Authorizations

Please review each item below and initial to indicate your understanding and consent.

Initials: _____	I agree to have my photograph taken and used in medical settings as appropriate for treatment.
Initials: _____	I agree to have my photograph used for medical records, research, and education when Dr. Godwin determines it may be of value to medical knowledge, with the understanding that I will not be identified by name and identifying characteristics will be minimized.
Initials: _____	I agree to the use of TouchMD, the software used by our practice to capture and store before/after photos, during my visits.
Initials: _____	I permit a copy of this release to be used in place of the original.

For Medicare Patients Only *(if you do not have Medicare, leave this section blank)*

Initials: _____ I authorize the release of medical information necessary to process claims to Medicare, for the purpose of filing and payment. I authorize payment of medical benefits directly to Dr. Godwin for services rendered.

Initials: _____ I agree to pay any deductible, co-payment, or coinsurance applied by Medicare, in addition to any uncovered service rendered by Dr. Godwin.

Initials: _____ I understand that Godwin Plastic Surgery participates with Medicare only and does not bill secondary or supplemental insurance of any kind. I am responsible for the remaining balance (typically 20%) that Medicare does not cover, including any deductible not yet met.

Signature of Patient _____ Date _____

Print Name _____