

PLASTIC SURGERY ASSOCIATES PATIENT INFORMATION

PATIENT'S FULL NAME _____ DATE _____

ADDRESS _____ E-mail _____
NO. & STREET CITY STATE ZIP

HM PH # (_____) _____ WK PH # (_____) _____ CELL # (_____) _____

PATIENT'S AGE _____ BIRTH DATE ____/____/____ SS# ____/____/____

SEX: M F MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED SPOUSE NAME _____

EMPLOYER _____ OCCUPATION _____

BUSINESS ADDRESS _____
NO. & STREET CITY STATE ZIP

REFERRED BY _____ NAME OF FAMILY PHYSICIAN _____

NAME OF RELATIVE OR CLOSE FRIEND NOT LIVING WITH YOU _____

HM. # (_____) _____ RELATIONSHIP TO PATIENT _____

REASON FOR TODAY'S VISIT _____

DUE TO INJURY? INJURY DATE ____/____/____ ON THE JOB? _____ AUTO ACCIDENT? _____

RESPONSIBLE PARTY (If different from patient)

NAME OF SPOUSE OR PARENT IF PATIENT IS A MINOR _____

ADDRESS _____
NO. & STREET CITY STATE ZIP

HM PH # (_____) _____ WK PH # (_____) _____ RELATIONSHIP TO PATIENT _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____

NAME OF INSURED _____ NAME OF INSURED _____

DATE OF BIRTH ____/____/____ DATE OF BIRTH ____/____/____

SSN ____/____/____ SSN ____/____/____

RELATIONSHIP OF PT. TO INSURED _____ RELATIONSHIP OF PT. TO INSURED _____

EMPLOYER NAME _____ EMPLOYER NAME _____

NOTICE OF PRIVACY PRACTICE: I have received my copy of the ***Notice of Privacy Practice*** from Plastic Surgery Associates.

PATIENT SIGNATURE DATE _____

METHOD OF PAYMENT FOR TODAY'S SERVICE: CASH CHECK CREDIT CARD

ASSIGNMENT OF BENEFITS:

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including private insurance and any other health plans, to Plastic Surgery Associates. I transfer my title of reimbursement from my insurance company to a doctor of Plastic Surgery Associates. I hereby agree to pay any and all charges that exceed or that are not covered by insurance. I hereby authorize said assignee to release all information necessary to secure payment. I authorize my insurance claim form to be sent via electronic claim filing. I authorize the release of my medical records or insurance claims to be sent via fax. 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.

SIGNATURE: _____ DATE: _____

WITNESS: _____