

Today's Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____

City: _____

State: _____

Zip Code: _____

Home Phone #: () _____

E-mail address: _____

Date of Birth: _____ Age: _____

SSN: _____

Sex: _____

Marital Status: _____

Spouse's Name: _____

Person Responsible for Payment: _____

Patient Employer

Spouse Employer

Company: _____

Address: _____

Phone: _____

Occupation: _____

Reason for consultation/Procedure(s) interested in:

Current Physicians (names only):

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

How Did You Hear About Us?:

Primary Insurance (if applicable)

Secondary Insurance (if applicable)

Company: _____

Address: _____

Phone: _____

Group #: _____

Policy Holder: _____

Holder SSN: _____

I authorize payment of medical benefits to Plastic & Reconstructive Surgery, P.C. I also authorize the release of any medical information to process this claim.

The above information is warranted to be true. I understand that the ultimate financial responsibility is mine, even though I may have insurance that should cover these services or have private agreement with another party. I hereby authorize Plastic & Reconstructive Surgery, P.C. to investigate any information obtained from me pertaining to my financial responsibility. I also agree to pay reasonable collection costs to collect any past due amounts.

Patient's Signature

Signature of Responsible Party (if different)