

How were you referred to our office? _____

Patient Information

Patient Name:
(Last) _____ (First) _____ (MI) _____
Date of Birth: ___/___/___ Social Security: _____ DriversLicense#: _____ State _____
Address: _____ Apt: _____
City: _____ State: _____ Zip: _____
Best contact phone number, circle one: Cell, Home, or Work
Cell: _____ Home: _____ Work: _____
E-mail: _____
Employer: _____ Occupation: _____
Address: _____
City: _____ State: _____ Zip: _____

Insurance and Policy Holder Information

Primary Insurance Company:

Policy # _____ **Group #** _____
Insurance Company Address: _____
City _____ State _____ Zipcode _____
InsuranceCompanyPhone: _____ PolicyHolderRelationship _____
☐ Check box if Policy Holder Information (below) is same as Patient Information
Policy Holder Information: Name:
(Last) _____ (First) _____ (MI) _____
Date of Birth: ___/___/___ Social Security: _____ DriversLicense#: _____ State _____
Address: _____
Apt: _____
City: _____ State: _____ Zip: _____
Best contact phone number for policy holder, circle one: Cell, Home, or Work
Cell: _____ Home: _____ Work: _____
Policyholder email: _____
Policyholderemployer: _____ Occupation _____
Policyholderemployeraddress: _____
City: _____ State: _____ Zip: _____

Secondary Insurance Company:

Policy # _____ **Group #** _____
Insurance Company Address: _____
City _____ State _____ Zipcode _____
Insurance Company
Phone: _____ PolicyHolder/Relationship _____
☐ Check box if Secondary Insurance Policy Holder Information (below) is same as Primary Insurance
Policy Holder Information: Name:
(Last) _____ (First) _____ (MI) _____
Date of Birth: ___/___/___ Social Security: _____ DriversLicense#: _____ State _____
Address: _____
Apt: _____
City: _____ State: _____ Zip: _____
Best contact phone number for policy holder, circle one: Cell, Home, or Work
Cell: _____ Home: _____ Work: _____
Policyholder email: _____
Policyholderemployer: _____ Occupation _____
Policyholderemployeraddress: _____
City: _____ State: _____ Zip: _____

Release of Medical Information:

Who may we share your medical information with?

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____

Emergency Contact Information:

Name of Person to Contact in an Emergency: _____

Relationship to Patient: _____

Phone number: _____ Alternate number: _____

Consent for treatment:

I voluntarily give my permission to the health care provider(s), associates, and such assistant(s) as they may deem necessary to provide medical services to me. I understand by signing this form, I am authorizing them to treat me for as long as I seek care from the physician and associates, or until I withdraw my consent in writing.

Statement of Financial Responsibility/Assignment of Benefits:

I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by Plastic Surgery Associates. I assign and authorize payments to Plastic Surgery Associates. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law.

Patient or Guardian Signature: _____ Date: _____

Photo Consent

Patient _____ Age _____

I authorize Plastic Surgery Associates, and office staff ("Authorized Parties") to take pre-, intra-, and post-operative photos during the course of my evaluation and treatment.

I understand that the photos may be stored on electronic or paper medical records. As able, patient identifying features are excluded.

I approve the photos to be used for the following purposes:

- Clinical documentation
- Testing and credentialing with the American Board of Plastics Surgeons
- Educational activities directed at patients and other physicians
- Presentations to medical and non-medical organizations
- Presentation at local, regional, national, or international meetings
- Publication in medical journals
- Marketing purposes such as brochures, educational pamphlets, and website

I understand my clinical care will not be affected by my choice to authorize or not authorize use of the photographs for the above stated purpose.

I hereby release and hold harmless the Authorized Parties of and from any and all claims, demands, damages or causes of action in connection with the use of the photographs I have hereby authorized.

Patient or Guardian Signature: _____ Date: _____