Patient Information

Patient Name:
(Last)_____(First)_____(MI)_____
Date of Birth: _____/_____/_____Social Security:_____
Drivers License#:_____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:_____
Pharmacy Name: _____ Pharmacy Phone _____
Pharmacy Address: _____

Insurance and Policy Holder Information

Patient or guardian is responsible for notifying our office of any changes to demographics or insurance and billing information. Failing to do so may result in unpaid claims, and you will be responsible for the balance of the claim. Our office does not accept responsibility for incorrect information given by you or your insurance carrier regarding your insurance benefits or benefit plans.

Primary Insurance Company: _____
Policy #_____ **Group #**_____
Insurance Company Address: _____
City_____State_____Zip Code_____
Insurance Company Phone:_____ Policy Holder Relationship:_____
☐ Check box if Policy Holder Information (below) is same as Patient Information
Policy Holder Information: Name:
(Last)_____(First)_____(MI)_____
Date of Birth: _____/_____/_____Social Security:_____
Drivers License#:_____State_____
Address: _____ Apt:_____
City: _____State: _____ Zip:_____
Best contact phone number for policy holder, circle one: Cell, Home, or Work
Cell:_____ Home: _____ Work:_____
Policy holder email:_____
Policy holder employer:_____Occupation_____
Policy holder employer address:_____
City: _____State: _____ Zip:_____

Secondary Insurance Company: _____
Policy #_____ **Group #**_____
Insurance Company Address: _____
City_____State_____Zip Code_____
Insurance Company Phone:_____ Policy Holder 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:_____
Drivers License#:_____State_____
Address: _____ Apt:_____
City: _____State: _____ Zip:_____
Best contact phone number for policy holder, circle one: Cell, Home, or Work
Cell:_____ Home: _____ Work:_____
Policy holder email:_____
Policy holder employer:_____Occupation_____
Policy holder employer address:_____
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: _____
Address: _____

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 Christine Fisher, MD. I assign and authorize payments to Christine Fisher, MD. 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 Christine Fisher MD 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 Plastic Surgeons

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, damagers or causes of action in connection with the use of the photographs I have hereby authorized.

Patient or Guardian Signature: _____ Date:_____