PLASTIC SURGICAL SPECIALISTS, PLLC

Patient Information

First Name: _____ MI: _____

Last Name: _____

Social Security #: _____

Sex: M F Marital Status: _____

Date of Birth: _____ Age: _____

Race: _____ Ethnicity: _____

Preferred Language: _____

Street Address: _____

City, State, Zip: _____

Employer: _____

Occupation: _____

Home Phone: ( ) _____

Work Phone: ( ) _____

Cell Phone: ( ) _____

May we contact you via text? Y N

Preferred Phone Number? Home | Work | Cell

What is your preferred method of contact?

☐ Email Address: _____

☐ Paper/US Mail

Have you ever been seen in this office before? Y N

If yes, who did you see and how long ago? _____

RELEASE OF PAYMENT/MEDICAL INFORMATION

I request that payment of authorized insurance benefits be made on my behalf to Plastic Surgical Specialists, PLLC. for any services furnished to me. I authorize the release of medical information needed to determine benefits.

Signature: _____

Date: _____

If patient is a minor, responsible party: _____

PHARMACY

Pharmacy: _____

Phone: ( ) _____

EMERGENCY CONTACT

Emergency Contact: _____

Relationship: _____

Emergency Contact Phone: ( ) _____

REFERRING PROVIDER

Referring Provider: _____

Address: _____

Phone: ( ) _____

PRIMARY INSURANCE

Name of Insurance: _____

Name of Subscriber: _____

Subscriber's Date of Birth: _____

Member ID#: _____

Your Relationship to the Subscriber: _____

SECONDARY INSURANCE

Name of Insurance: _____

Name of Subscriber: _____

Subscriber's Date of Birth: _____

Member ID#: _____

Your Relationship to the Subscriber: _____

Is your visit today the result of a work injury? Y N

Is your visit today the result of an auto accident? Y N

FOR MEDICARE PATIENTS:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Plastic Surgical Specialists, PLLC. for any services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Finance Administration and its agents any information needed to determine these benefits payable for services.

Signature: _____

Date: _____