

# SPECIALISTS IN PLASTIC SURGERY, P.A.

Patient Information as of \_\_\_\_\_ . **(Please Print Legibly & Fill In or Correct All Fields)**

CHART #: \_\_\_\_\_ DOCTOR: \_\_\_\_\_

NAME: \_\_\_\_\_  
LAST FIRST MIDDLE

ADDRESS: \_\_\_\_\_  
STREET AND APT # CITY STATE ZIP CODE

AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ GENDER: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

SOC. SEC. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

Preferred method(s) to contact you: Home  Cell  Work  Email

EMPLOYED BY: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

SPOUSE'S/SIGNIFICANT OTHER'S NAME: \_\_\_\_\_ SPOUSE'S WORK PHONE: \_\_\_\_\_

SPOUSE'S/SIGNIFICANT OTHER'S EMPLOYER: \_\_\_\_\_

SPOUSE'S DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SPOUSE'S SOC. SEC. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

REFERRED BY FRIEND - NAME: \_\_\_\_\_

REFERRED BY PHYSICIAN - NAME: \_\_\_\_\_

PRIMARY MEDICAL DOCTOR - NAME: \_\_\_\_\_

EMERGENCY CONTACT - NAME (Outside the Home): \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ HOME/CELL PHONE: \_\_\_\_\_

RESPONSIBLE PARTY (Please complete only if patient is a minor.)

NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_  
LAST FIRST MIDDLE

ADDRESS: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_  
STREET AND APT # CITY STATE ZIP CODE

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ SOC. SEC. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ EMPLOYED BY: \_\_\_\_\_

I authorize Dr. \_\_\_\_\_ to bill my insurance company and authorize all of my insurance benefits to be paid directly to Dr. \_\_\_\_\_. Regardless of whether I have insurance coverage or am a self-pay patient, I understand that I am responsible for all bills, co-pays, deductibles and non-covered services being paid in a timely manner. I authorize all pertinent information to be released to my referring physicians, primary care physicians and my insurance carriers. I understand payment is due at the time services are rendered. I understand that the parent or guardian requesting treatment for a minor is responsible for all fees for services rendered.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Patient or Responsible Party