

Patient Information Sheet

Patient Legal Name _____ Nickname _____
Last First Initial

Sex _____ Date of Birth _____ Age _____ Social Security # _____

Marital Status: Single Married Divorced Widowed Separated

Home Address _____
Street City State Zip

Home Phone # _____ Alternate/ Cell Phone # _____

Employer _____ Work Phone # _____

Name of Closest Relative, Friend or Neighbor _____ Phone # _____

Patient Primary Care Physician _____ Phone # _____

Referred by Dr. _____ Phone Book Radio Postcard Website Other

Specific Reason for Visit _____

Email Address _____ May we contact you via email? Yes No

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Insurance

Name of Policy Holder _____ Effective Date of Coverage _____

Policy Holder's SSN _____ Sex _____ DOB _____

Policy Holder's Employer _____

Patient's Relationship to Policy Holder Self Spouse Child Other

ID/Policy # _____ Group # _____

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I, _____, represent to the physician and staff that I am at least 18 (eighteen) years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and the treatment by my doctor and such assistant or staff as may be assigned by him.

I authorize the release of any medical information for the purposes of processing insurance claims on my behalf. I authorize payments of any medical benefits directly to the doctor for services provided to me. A copy of the authorization shall be considered as valid as the original. In the event of any litigation arising from treatment, I agree to submit the case to arbitration. I understand that photography is a necessary part of planning and evaluating cosmetic or reconstructive surgery. I authorize the taking of photographs at the direction of my surgeon and under such conditions as may be approved by him. These photographs will be used solely for documentation purposes and will be kept confidential.

I understand that there may be a consultation fee for the initial visit which is due at the time of my appointment unless other arrangements have been made in advance.

SIGNATURE: _____

DATE: _____