Patient Information Form

DATE:

Patient Name (last/first/MI): Maiden Name:

Street Address: Home Phone:

City: State: Zip: Cell Phone:

Birthdate: SS#:

Employer: Occupation:

Employer's Address: Phone Number:

Is patient responsible party? Yes No Date Retired:

Marital Status: M S W D Sex: Male Female

Emergency Contact: Phone Number:

Spouse/Parent Name: Phone Number:

Address: City: State: Zip:

Birthdate: SS#:

Employer: Occupation:

Employer's Address: Phone Number:

City: State: Zip:

Relation to Patient: Wife Husband Child Parent Other

Primary Physician: Phone Number:

Referring Physician: Phone Number:

Primary Insurance Company:

Street Address: Phone Number:

City: State: Zip:

ID#: Group #:

Name of Policy Holder: Through Employer: Yes No

Secondary Insurance Company:

Street Address: Phone Number:

City: State: Zip:

ID#: Group #:

Name of Policy Holder: Through Employer: Yes No

Please carefully read the following before signing below.

Unless you are a member of an insurance company that is contracted with Parkcrest Plastic Surgery, Inc, payment for services are expected on the day of the visit. All co-payments must be paid at time of service. Payment may be made by check, cash, or credit card.

I authorize Parkcrest Plastic Surgery, Inc. to release any information acquired in the course of my examination or treatment to my insurance company in order to file a claim. I also understand that there may be a balance due from my after my insurance pays their portion. I also authorize payment directly to and assign to Parkcrest Plastic Surgery, Inc. any surgical/medical benefits. A photo static copy of this release shall be valid as the original. I understand that if my account is not paid when due, I will be responsible for all costs incurred in the collection process of my account. I further understand that my account will be reported to a credit bureau.

Parkcrest Plastic Surgery, Inc. does not deny benefits or services because of race, color, national origin, age, sex, disability, religious, or political beliefs. If you feel you have been discriminated against, you may file a Complaint of Discrimination with the Administrator of this facility. You will not suffer any penalty because you file a complaint.

I acknowledge that I have received a copy of Parkcrest Plastic Surgery's **"Notice of Privacy Practices"** and consent to the use or disclosure of my protected health information by Parkcrest Plastic Surgery for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, to conduct health care operations of Parkcrest Plastic Surgery and as required by law.

Signature of Patient/Responsible Party: Date:

Revised 03/03