

CHART NUMBER:

Plastic Surgery Affiliates Patient Information Form

PLEASE PRINT ALL ENTRIES AND SIGN/DATE FORM

Full Legal Name (Last, First, MI)				Date of Birth ____/____/____		E-MAIL ADDRESS	
Address (Street)				City		State	ZIP
Age	Sex	Marital Status	Height	Weight	What phone number will be the best way to reach you during the day?		
Home Phone (____) ____-____			Work Phone (____) ____-____			Cell Phone (____) ____-____	
Employer Name				Occupation		Social Security No. (REQUIRED)	
Employer Address (Street)		City		State		Zip	
Spouse's Full Legal Name (Last, First, MI)			DOB ____/____/____	Social Security No.		Spouse's Work Phone (____) ____-____	
Guardian's Name if patient is under 18 (Last, First, MI)			DOB ____/____/____	Social Security No.		Home Phone (____) ____-____	
Emergency Contact			Relationship			Phone (____) ____-____	
Who is your primary care or family doctor?			Address of family doctor			Phone of family doctor	

How did you hear about us?

INSURANCE INFORMATION

Primary Insurance Name				AC			
Name of Subscriber (As it appears on your card)		Relationship		GROUP Number		ID Number	

1. I authorize treatment for myself (or dependent if patient is a minor) by Plastic Surgery Affiliates and its staff.
2. **I am responsible for any co-pay, co-insurance, deductible, or charges not covered by my insurance.**
3. I authorize payment of benefits by my insurance company to Plastic Surgery Affiliates, INC.
4. I agree to the financial policy of Plastic Surgery Affiliates (a copy has been given to me). I understand I am liable for court costs, attorney's fees, and collection agency fees in order to collect an unpaid balance on my account.
5. I release the use of any photographs taken of me for research, teaching, or marketing purposes without remuneration.

SIGNATURE: _____ **DATE:** _____