



Center for Plastic Surgery, P.C.

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Member



AMERICAN SOCIETY OF PLASTIC SURGEONS

Welcome to our office, we are happy to have you! Please take the time to fill out the following forms so that we may better assist you.

PATIENT INFORMATION

Name _____

Last

First

Middle Initial

Social Security Number _____ Date of Birth ____/____/____ Present Age _____ Gender: Male Female

Marital Status: Single Married Divorced Widowed Separated Partnered Minor

Home Phone Number (____) _____ Work Number (____) _____

Cell Phone Number (____) _____ Fax Number (____) _____ Primary Contact Number: Home Work Cell

Address _____

Street Address/apt #

City, State

Zip Code

Email _____ Who may we thank for referring you? _____

Patient Employer/School _____ Occupation _____

Employer/School Address _____ Employer/School Phone (____) _____

In case of emergency who should be notified? _____ Relation: _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____

Last

First

Middle Initial

Relation to patient _____ Date of Birth ____/____/____ Soc. Sec. # _____

Address (if different from patient's) _____

Street Address/Apt #

City, State

Zip Code

Phone (____) _____ Person Responsible Employed by: _____

Business Address _____ Business Phone (____) _____

Insurance Company _____

Contract # _____ Group # _____

Names of other dependents covered under this plan _____

SECONDARY INSURANCE

Subscriber Name _____ Date of Birth ____/____/____ Relation to patient _____

Address (if different from patient's) _____

Street Address/Apt #

City, State

Zip Code

Phone (____) _____ Social Security # _____ Subscriber Employed by: _____

Business Phone (____) _____ Insurance Company _____

Contract # _____ Group # _____

Names of other dependents covered under this plan _____

ASSIGNMENT and RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Peter C. Haines all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that there will be a \$25.00 fee for any returned check. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

SIGNATURE of Patient/Parent/Guardian or Personal Representative

DATE

Please PRINT NAME of Patient/Parent/Guardian or Personal Representative

Relationship to Patient