PLASTIC SURGERY CONSULTANTS

Name:	Marital Status: S M W D	Date of Birth:	Age:	Social Security #:
Street Address:	City:	State:		Zip Code:
Home Phone:	Work Phone:	Mobile Phone:		Email Address:
Employed By: (Indicate if Retired)		Occupation: (Indicate If Student and Give Name of School)		
Employer's Street Address:		City :	State:	Zip Code:
Person Responsible for Payment:		City, State & Zip Code:		Home Phone:
Spouse's Name:		Spouse's Social Security No.:		
Spouse Employed By (Retired?)	Occupation or Student	How Long Employed:		Bus. Phone:
Referred By:				

Emergency Contact Information

Name:	Relationship:	You have my permission to speak with and release information to this person about my medical care.
Address:	Telephone Number:	YES NO
Name:	Relationship:	You have my permission to speak with and release information to this person about my medical care.
Address:	Telephone Number:	YES NO

If this is a Worker's Compensation, or Auto Accident, Please Complete the Following:

Date of Accident:	Name, Address, and Phone # of Attorney If Attorney is Handling This Case:
If Worker's Comp., Person to Contact to Verify:	Phone:

I consent to communication via secure text message. __Yes __No _____ Initial

I consent to receiving detailed voice messages on my telephone numbers provided. __Yes __No _____ Initial

I acknowledge full responsibility for the payment of services rendered to me and agree to pay for them in full, AT THE TIME OF SERVICE, unless other arrangements are made in advance with the office. I understand and agree that health insurance policies are in arrangement between an insurance carrier and myself. I will take the responsibility for any and all costs incurred by my failure to remit for service rendered. I authorize payment of medical benefits to the physician herein for medical services rendered. A photocopy of this signature is as valid as the original. I also authorize the physician to release any information required in processing of insurance.

Signature **Name** **Date**