

PATIENT INFORMATION

Patient Name LAST FIRST MIDDLE
Date of First Visit Account #
Date of Birth Age Sex Race SS#
Street Address City State Zip
Mailing Address City State Zip
Home Phone Work Phone Cell Phone
Employer Address
Driver's License # State of Issue E-mail address

PARENT OR SPOUSE INFORMATION

Name Relationship SS#
Mailing Address (if different from Patient)
Home Phone Work Phone
Employer Address
Driver's License # State of Issue

Physician to be seen: DR. FRANK STIEG

Referred by Address Phone
May we write a letter to your referral source, thanking them for referring you? Yes No
Reason for Visit
Have you been treated elsewhere for this problem? If so, by whom?
Have you or any of your family members been treated here before?
Name/Address of Primary Care Physician

Do you authorize the release of medical records to:

Your primary care doctor? Yes No SIGNATURE DATE
Your referring doctor? Yes No SIGNATURE DATE

IF ACCIDENT RELATED, PLEASE COMPLETE THE FOLLOWING

Date of Accident Time Describe how accident happened:
Any legal proceedings involved regarding this visit Yes No
NAME OF INSURANCE CARRIER:
How do you plan to pay for this visit? Cash Check Insurance Credit Card

EMERGENCY CONTACT PERSON

Emergency contact person (or friend) other than a relative, who does not reside with you:
Name Address Phone

PRIMARY INSURANCE INFORMATION

Insurance company _____
Group or Individual _____
If Group, Name of Employer _____
Policy # _____ Group # _____
Insured's Name _____ Relation to Patient _____
Insured's SS# & Date of Birth _____ Ins. Co. Phone # _____
Mail Claims To: _____

SECONDARY OR WORKER'S COMPENSATION INSURANCE INFORMATION

Insurance company _____
Group or Individual _____
If Group, Name of Employer _____
Policy # _____ Group # _____
Insured's Name _____ Relation to Patient _____
Insured's SS# & Date of Birth _____ Ins. Co. Phone # _____
Mail Claims To: _____

INSURANCE RELATED SERVICES

The patient is responsible for all fees, subject to individual insurance requirements. We accept payment in the form of cash, check, or credit card. When insurance coverage applies, our office will complete the necessary forms (using information that you provide) to expedite insurance payments. Prior authorization of services (especially surgery) and pre-verification of coverage may be necessary. Depending upon insurance coverage, you will be asked to pay deductible amounts, co-payments and charges for non-covered services.

I authorize release of medical information necessary to process this claim and also authorize payment of medical benefits to the physician. I hereby authorize Plastic Surgery Specialists, P.A. to furnish information to insurance carriers concerning my illness and treatment and I hereby assign to the physician (s) all payments for medical services rendered to myself or my dependents.

DATE: _____ SIGNATURE: _____

NON-INSURANCE RELATED SERVICES

The patient is responsible for all fees for any and all services provided by our physicians. I agree to pay for all services rendered by my physician per the office policy of Plastic Surgery Specialists, P.A.

DATE: _____ SIGNATURE: _____