LAKEVIEW Plastic Surgery
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PATIENT INFORMATION Today's Date ___/___/___

Name: _____
Last First M.I.

Mailing Address: _____
Street City State Zip Code

Home Phone: (___) _____ Ok to leave message? ❑ Yes ❑ No
Work Phone: (___) _____ Ok to leave message? ❑ Yes ❑ No
Cell Phone: (___) _____ Ok to leave message? ❑ Yes ❑ No

Email address: _____ Occupation: _____

Date of Birth: ____/____/____ SSN: ____-____-_____ Marital Status: _____ Spouse/Partner Name: _____

Age: _____ Sex/Gender: ____ Employment: ❑ FT ❑ PT ❑ FT-Student ❑ PT-Student ❑ Retired ❑ Unemployed

PATIENT OR RESPONSIBLE PARTY (if different from patient)

Name: _____
Last First M.I.

Mailing Address: _____
Street City State Zip Code

Home Phone: (___) _____ Ok to leave message? ❑ Yes ❑ No
Work Phone: (___) _____ Ok to leave message? ❑ Yes ❑ No
Cell Phone: (___) _____ Ok to leave message? ❑ Yes ❑ No

Date of Birth: ____/____/____ SSN: ____-____-_____ Marital Status: _____ Spouse Name: _____

INSURANCE INFORMATION

Primary Insurance Co. Name _____
Name of Insured _____
Address of insured _____
_____
DOB of insured _____
Employer Name _____
Relationship to insured _____

Secondary Insurance Co. Name _____
Name of Insured _____
Address of insured _____
_____
DOB of insured _____
Employer Name _____
Relationship to insured _____

In case of Emergency, who should be notified? _____ **Phone** (_____) ____-_____

Can we discuss your medical conditions with other members of your household? ❑ Yes ❑ No ❑ Specify: _____

Referred by: ❑ Physician _____ ❑ Family/Friend _____

How did you hear about us? ❑ Friend/Family ❑ Internet ❑ Advertisement ❑Insurance Referral ❑ Physician ❑Other _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the physician.

In order to establish optimal relationships with our patients and avoid misunderstanding and confusion regarding out payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in an insurance plan in which we participate. For those patients,applicable copayments will be collected. We accept payment in the form of cash or credit card. If we do accept a check for payment, and the check does not clear the bank, a $25.00 service fee will be automatically added to your account. Please note that any procedures performed in the office may be billed separately and in addition to the office visit fee. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature _____ Date: ____/____/_____

If patient is a minor, print name of responsible party _____ Relationship _____