SUMMIT Plastic Surgery & Dermatology

Last Name: _____ First Name: _____MI:_____

Address: _____ City:_____State: ___ Zip: _____

Date of Birth: _____ SS# _____ Age:_____ Sex:_____

Email: _____ Employer: _____

Marital Status: (please circle) Single Married Divorced Widowed

Home Phone# _____Cell Phone# _____

(Please Circle Preferred Phone Number)

Emergency Contact: _____ Phone # _____

I give permission for my medical information and/or test results to be released to:

Name: _____Relationship:_____

Can we leave a message on your cell phone/answering machine? Yes No

Primary Physician: _____ Referring Physician:_____

Pharmacy Name & Location: _____Phone #_____

How did you hear about our office? Radio _____ TV _____ Website ____ Billboard _____Other_____

Spouse/Responsible Party Information

Last Name: _____ First Name: _____MI:_____

Address: _____ City: _____ State: _____ Zip_____

Date of Birth: _____ SS# _____ Employer: _____

Assignment and Release: I hereby authorize and direct my insurance carrier to pay directly to Summit Plastic Surgery & Dermatology all insurance benefits, if any, due to me under my insurance plan. I further agree to pay the balance of the charges not paid by my insurance. I hereby authorize the release of any information necessary to secure payment of benefits. I also authorize the use of this signature on all insurance submissions. If the patient is a minor, I as a legal guardian, give consent for treatment for this and future services rendered.

Signature of patient/guardian:_____ Date: _____