The Beauty of Transformation

Patient's Information

Today's Date:_____/_____/_____

Name:_____ Sex: ☐ M ☐ F
Last First MI

Date of Birth:____/____/_____ Soc Sec#:_____ -_____ -_____ Marital Status: ☐ S ☐ M ☐ D ☐ W

Home Phone: (_____)_____ Cell Phone: (_____)_____

Address: _____ Apt#_____ City: _____ State____ Zip:_____

Employer: _____ WorkPhone: (_____)_____

Email: _____ Reason for Consult:_____
(Supplying your email gives us permission to communicate electronically)

How did you hear about us?
☐ Our Website ☐ Google Search ☐ Facebook ☐ Friend/Family Member ☐ Physician

***If you were referred by a friend or family member ask us about our referral/rewards program.

☐ Race:
☐ White
☐ African American
☐ Asian

☐ Ethnic Group:
☐ Not Hispanic / Latino
☐ Hispanic / Latino
☐ Decline to

☐ Primary Language:
☐ English
☐ Spanish
☐ Other

Guarantor's Information

Name:_____ Sex: ☐ M ☐ F
Last First MI

Date of Birth:____/____/_____ Soc Sec#:_____ -_____ -_____ Marital Status: ☐ S ☐ M ☐ D ☐ W

Home Phone: (_____)_____ Cell Phone: (_____)_____

Address: _____ Apt#_____ City: _____ State____ Zip:_____

Employer: _____ Work Phone: (_____)_____

Emergency Contacts - Please include someone who does NOT live with you.

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

Patient's Insurance Information *(The accuracy of this information is extremely important in the processing of your claims. Inaccuracies may result in the patient being responsible and billed for services rendered)*

1. **Primary Insurance:** _____ **Subcriber's Name:** _____

Subscriber's DOB: ____/____/____ **Subscriber's SS#:** _____ - _____ - _____ **Relationship:** _____

2. **Secondary Insurance:** _____ **Subcriber's Name:** _____

Subscriber's DOB: ____/____/____ **Subscriber's SS#:** _____ - _____ - _____ **Relationship:** _____

3. **Other:** _____

_____

_____

I request that payment of authorized insurance benefits be made on my behalf to the provider indicated above for services furnished to me. I authorize any holder of medical information about me or my dependent to release to the insurance company any information needed to determine these benefits or the benefits payable for related services. A photocopy of this assignment is to be considered as the original. I understand that I am financially responsible for all charges whether or not covered by said insurance. This assignment will remain in effect until revoked by me in writing . I further agree to pay the cost of collection, court costs, and other reasonable fees should they be required in the event of my non-payment. (If this patient is a minor child, the parent signing this form will be financially responsible for the child. Any legal agreement, or other disagreement, between parents in a divorce must be dealt with between those parties and does not involve Plastic Surgical Arts.

X_____

Signature of Patient or Guardian if patient is 18 or under