Patient Number ____________ **Email Address**________________________________ Date______________

Please Complete the Following:

PATIENT NAME____ PHONE______________

ADDRESS____ City______________________________State________ZIP______________

SEX: MALE ☐ FEMALE ☐ BIRTHDATE _______________AGE_________ SOCIAL SECURITY NO.________________________

EMPLOYER____ PHONE______________________________

NAME OF SPOUSE________________________________ SPOUSE'S EMPLOYER____

NAME OF NEAREST RELATIVE (OTHER THAN SPOUSE)____

ADDRESS____

PHONE____ RELATION TO PATIENT__________________________________

REFERRED BY:____

REASON FOR APPOINTMENT:____

IF NOT AN ILLNESS, IS PATIENT'S CONDITION RELATED TO : ☐ EMPLOYMENT ☐ AUTO ACCIDENT ☐ OTHER ACCIDENT

DATE OF INJURY/ACCIDENT: ____

INSURANCE

WILL THIS CLAIM BE COVERED UNDER WORKMEN'S COMPENSATION? YES ☐ NO ☐

IF YES, NAME OF COMPANY___________________________________ PHONE _______________________

ADDRESS____

YOUR PERSONAL INSURANCE: (INCLUDE PRIVATE, GROUP AND SPOUSE'S)

1.__________________________ Insurance Company	______________________________ ID/Policy/Group Number
2.__________________________ Insurance Company	______________________________ ID/Policy/Group Number

Children and Dependent Adults

Responsible Parent/Guardian/Power of Attorney

NAME_________________________PHONE_________________ RELATION TO PATIENT__________

ADDRESS____

STATUS WITH CHILD'S OTHER PARENT: Married ☐ Divorced ☐ Separated ☐

INSURANCE COVERAGE THROUGH: Father ☐ Mother ☐ Other ☐

EMPLOYER________________________________ADDRESS_______________________________

S.S. NUMBER_______________________________D.O.B.__________________________________

AUTHORIZATION TO RELEASE INFORMATION AND PAY BENEFITS TO PHYSICIANS

I HEREBY AUTHORIZE COLUMBIA PLASTIC SURGERY TO RELEASE ANY INFORMATION TO THE INSURANCE COMPANY COVERING MY PROCEDURES OR ANY SERVICES RENDERED. I ALSO AUTHORIZE DIRECT PAYMENT TO COLUMBIA PLASTIC SUREGERY BY THE INSURANCE COMPANY OF ANY BENEFITS DUE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THE ASSIGNMENT.

PLEASE SIGN

SIGNATURE	DATE