

PLEASE COMPLETE ALL AREAS

PATIENT

NAME FIRST-MIDDLE-LAST						AGE	APPOINTMENT DATE
STREET ADDRESS					CITY	STATE	ZIP
HOME PHONE	WORK PHONE	SEX M <input type="checkbox"/> F <input type="checkbox"/>	MARITAL STATUS S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> DIV <input type="checkbox"/> SEP <input type="checkbox"/>	DATE OF BIRTH	SOCIAL SECURITY NUMBER		
CELL PHONE	EMAIL ADDRESS						
EMPLOYER NAME (IF MINOR, MOTHER'S NAME)			ADDRESS		CITY - STATE - ZIP		OCCUPATION /STUDENT?
HOW DID YOU HEAR ABOUT US?		<input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> PREVIOUS PATIENT <input type="checkbox"/> OTHER		REFERRING PERSON			
		<input type="checkbox"/> FRIEND/FAMILY <input type="checkbox"/> LAWYER					
REFERRING PHYSICIAN NAME & PHONE				PHARMACY NAME & PHONE			

SPOUSE OR RESPONSIBLE PARTY

NAME FIRST - MIDDLE - LAST (IF MINOR, FATHER'S NAME)		RELATIONSHIP (MOTHER, FRIEND, ETC)	SOCIAL SECURITY NUMBER	HOME PHONE ( )	WORK PHONE ( )
STREET ADDRESS			CITY	STATE	ZIP
EMPLOYER NAME AND ADDRESS			CITY - STATE - ZIP	PHONE ( )	OCCUPATION

EMERGENCY CONTACT

PERSON TO CONTACT IN EMERGENCY (NEXT OF KIN)		THEIR RELATIONSHIP TO YOU	HOME PHONE ( )	WORK PHONE ( )
STREET ADDRESS			CITY - STATE - ZIP	

MEDICAL COMPLAINT (PART OF BODY) AND PRIOR TREATMENT

REASON FOR VISIT (BE SPECIFIC)			DURATION		
PRIOR TREATMENT			WHEN	WHERE	
BY WHOM			PRIOR X-RAYS	WHEN	WHERE
FAMILY PHYSICIAN		ADDRESS/PHONE			
IF VISIT DUE TO ACCIDENT	DATE OF ACCIDENT	PLACE OF ACCIDENT	REPORTED TO INSURANCE CO.? <input type="checkbox"/> YES <input type="checkbox"/> NO	STILL WORKING <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE STOPPED WORKING
HOW DID ACCIDENT HAPPEN?			ATTORNEY NAME / PHONE NO.		
THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE					DATE

INSURANCE INFORMATION

SECONDARY CARRIER

INSURANCE COMPANY		<input type="checkbox"/> HMO COPAY \$ _____	INSURANCE COMPANY		<input type="checkbox"/> HMO COPAY \$ _____
		<input type="checkbox"/> PPO COPAY \$ _____			<input type="checkbox"/> PPO COPAY \$ _____
PHONE			PHONE		
ID#	GROUP #	ID #	GROUP #		
INSURED PERSON	SS#	INSURED PERSON	SS#		
ADJUSTER NAME	PHONE	ADJUSTER NAME	PHONE		

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

MEDICARE AUTHORIZATION TO RELEASE INFORMATION AND MEDICAL ASSIGNMENT

I authorize the release of all medical information necessary to process this claim and pertinent to my medical care. I assign all medical and/or surgical benefits to Albear Plastic Surgery, PL. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

I request that payment of authorized Medicare benefits be made on my behalf to Albear Plastic Surgery, PL for any services furnished me. I authorize any holder of medical information about me to release to the offices of Albear Plastic Surgery, PL and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Signature (parent if minor)

DATE

Signature (parent if minor)

DATE

CONSENT FOR MEDICAL TREATMENT AND PHOTOGRAPHS

DO NOT COMPLETE THIS SECTION

I hereby give permission for medical evaluation and treatment in the offices of Albear Plastic Surgery, PL. I understand that this will entail the creation and maintenance of medical records and photographs. Photographs may be used, discreetly and anonymously, for the purpose of ethical patient education in office and on albearplasticsurgery.com web page.

WEIGHT	HT	TEMP	B/P	PULSE	RESP.
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ALLERGIES

Signature of patient or legal representative

DATE