



### PATIENT INFORMATION

\_\_\_\_\_  
Patient First Name, Middle Initial

\_\_\_\_\_  
Patient Last Name

Male \_\_\_ Female \_\_\_

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Home Phone Number

\_\_\_\_\_  
Mailing Address, if different from Street Address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Work Phone Number

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Patient Date of Birth

Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_

\_\_\_\_\_  
Cell Phone Number

\_\_\_\_\_  
Patient Employer Name

\_\_\_\_\_  
Email Address (confidential - not shared)

### RESPONSIBLE PARTY INFORMATION – IF DIFFERENT FROM PATIENT

\_\_\_\_\_  
Guarantor First Name

\_\_\_\_\_  
Guarantor Last Name

\_\_\_\_\_  
Home Phone Number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Work Phone Number

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Guarantor DOB

\_\_\_\_\_  
Employer Name

\_\_\_\_\_  
Cell Phone Number

### EMERGENCY CONTACT INFORMATION

\_\_\_\_\_  
Emergency Contact Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Home Phone Number

\_\_\_\_\_  
Contact Home Address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Work Phone Number

\_\_\_\_\_  
Cell Phone Number

### APPOINTMENT INFORMATION

\_\_\_\_\_  
Primary Doctor Name

\_\_\_\_\_  
Referring Physician

\_\_\_\_\_  
Reason for this visit

Is this visit related to an Auto or Work Accident?

Auto: Yes \_\_\_ No \_\_\_ Work: Yes \_\_\_ No \_\_\_

If yes, what is the date of injury?

\_\_\_\_\_  
Have you filed claim with your insurance company?

Yes \_\_\_ No \_\_\_

How did you hear about our office? Please circle all that apply:

Magazine Phone Book Website Facebook Event Newspaper

Doctor \_\_\_\_\_

Friend \_\_\_\_\_

Other \_\_\_\_\_



**THE CENTER**  
for Plastic Surgery & Skin Care  
231.929.7700

### INSURANCE INFORMATION: PRIMARY

\_\_\_\_\_  
Name of Insurance

\_\_\_\_\_  
Subscriber's Name and Relationship to Patient

\_\_\_\_\_  
Subscriber DOB

\_\_\_\_\_  
Contract Number

\_\_\_\_\_  
Insurance Company Phone

\_\_\_\_\_  
Subscriber Social Security #

\_\_\_\_\_  
Insurance Company Address, City, State, Zip

\_\_\_\_\_  
Effective Date Insurance

### INSURANCE INFORMATION: SECONDARY

\_\_\_\_\_  
Name of Insurance

\_\_\_\_\_  
Subscriber's Name

\_\_\_\_\_  
Subscriber DOB

\_\_\_\_\_  
Contract Number

\_\_\_\_\_  
Group Number

\_\_\_\_\_  
Subscriber Social Security #

\_\_\_\_\_  
Effective Date Insurance

### 1. ALL PATIENTS: PLEASE SIGN

I hereby authorize the release of medical information to my insurance carrier(s) for payment determination as well as other providers pertinent to my medical care.

I authorize The Center for Plastic Surgery, PC to leave information on my home answering machine or with whomever answers regarding appointment reminders and/or my need to call back.

Further, I authorize The Center for Plastic Surgery, PC to take photographs, pre- and post-treatment, for insurance authorizations and educational purposes.

\_\_\_\_\_  
Patient or Guardian (if under the age of 18 years)

\_\_\_\_\_  
Date

### 2. MEDICARE, WORKER'S COMPENSATION, MEDICAID (AGE 0-17 YEARS): PLEASE SIGN

I hereby authorize my insurance benefits to be paid to The Center for Plastic Surgery, PC for any services rendered to me.

I understand that The Center for Plastic Surgery, PC participates with Medicare. However, if my insurance provider indicates a service to be rendered will not be covered, I will be asked to sign a waiver. This waiver will state my insurance may not cover this service, and I will be fully responsible for payment.

\_\_\_\_\_  
Patient or Guardian (if under the age of 18 years)

\_\_\_\_\_  
Date

### 3. ALL OTHER INSURANCES: PLEASE SIGN

I understand that the providers at The Center for Plastic Surgery, PC only participate with Priority Health, BCBS, BCN, Medicare, McLaren Health Advantage, Worker's Compensation, and Medicaid (age 0-17 years). I authorize The Center for Plastic Surgery, PC to release information to my employer and/or insurance company and to assign benefits incurred to my Doctor. I further understand that the Doctor's fee may exceed what my insurance will pay and that I will be responsible for any balance.

\_\_\_\_\_  
Patient or Guardian (if under the age of 18 years)

\_\_\_\_\_  
Date