THE CENTER
FOR PLASTIC SURGERY
231.929.7700

DATE

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 _____

OVER →

THE CENTER
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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, WORKERS' 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 BCBS, Priority Health, Medicare, Medicaid for persons under 17, McLaren Health Plan, Cigna, and ASR. 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