PATIENT INFORMATION SHEET

PATIENT

First Name: ________________________ M.I.: ____ Last Name: ________________________

Address: ____

City: ________________________________ State: _________ Zip: ________________

Home Phone: (_______) ____________________ Work Phone: (_______) ____________________

Mobile Phone: (_______) __________________

Social Security #: ______________ D.O.B: ____________ Age: _____ Sex: _____ Race: _____

Occupation: ______________ Employer Name: ________________

Email address: ____________________

How did you hear about our practice? ________________

If patient is a minor (under 17) please complete for Insurance Purposes

Mother's Name: ______________________________ Mother's S/S #: ____________________

D.O.B: _________ Employer: ______________________ Work Tel: (_______) ____________

Father's Name: ______________________________Father's S/S #: ____________________

D.O.B: _________ Employer: ______________________ Work Tel: (_______) ____________

Legal Guardian Name:__________________________ Phone #: (_______) ________________

SPOUSE (if applicable)

First name: ______________________ Last Name: ________________________

Social Security # ____________________ Date of Birth ________________________

Occupation ______________________ Employer ________________________

EMERGENCY CONTACT

Name: ____________________ Tel (H): (_______) ____________ Tel (W): (______) ____________

Relationship to you:________________________

PHYSICIAN INFORMATION

Primary Care Doctor: ____Tel: (_____)___________________________

Address: __________________________________ City / State / Zip:____

Referring Doctor: ____ Tel: (_____)_____________________________

Address: __________________________________ City / State / Zip:____

Are you currently receiving treatment for any medical condition or under the care of any other physician other than your primary care physician or the referring physician? Yes/No

Name of physician: ____ *Tel: (_____)* _________________

What are you being treated for: ____

INSURANCE (IF APPLICABLE)

Primary Insurance: ____ **Policy Number** _____________________________

Name of person who carries the insurance: First ___________________________ Last ____________________________

Date of Birth of person carrying insurance:______________________ Social Security Number:_____________________

Secondary Insurance: ____ **Policy Number** _____________________________

Name of person who carries the insurance: First ___________________________ Last ____________________________

Date of Birth of person carrying insurance:______________________ Social Security Number:_____________________

WORKER'S COMPENSATION

Is this a worker's compensation claim: Yes/No (please circle one) Claim #: ___________________________________

Date of Injury: ___________ *Employer:* ___________________________________ *MCO:* ____________________________

PATIENT'S SIGNATURE

1. *I have the right to request a copy of Notice of Privacy Practices.*
2. *I understand that I am financially responsible for any balance.*
3. *I understand that co-payments or Consultation fees are due at the time of my visit.*
4. *I understand that I am responsible for informing the receptionist of any changes in address or insurance coverage.*
5. *I understand that I am responsible for providing a referral from my primary care physician (PCP), should my insurance carrier require one, and that if one is not received my appointment will be cancelled.*
6. *I authorize release of my medical information to the pertinent insurance company(ies) or third party carriers necessary to process claims.*
7. *I hereby assign payment of any and all benefits from insurance company(ies) to be made directly to Florida Plastic & Reconstructive Surgery.*

Signature: ____ Date: ____________________

Relationship to Patient____________________________________