

**PATIENT INFORMATION**

Social Security #: \_\_\_\_\_

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ MI: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apartment#: \_\_\_\_\_

Zip Code: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_ Race: \_\_\_ Marital: (*circle one*) Single Married Divorced Widowed Separated

**Employment:** (*circle one*) Full Part Retired None **Student:** Full Part

Relationship to Insured: (*circle one*) SELF SPOUSE CHILD OTHER

Employer Name: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Reason for Today's Visit: \_\_\_\_\_

**Accident?:** YES or NO *If Yes*, Date of Accident \_\_\_\_\_ Nature of Accident \_\_\_\_\_

**Do we have permission to:** Leave a message on your home answering machine? \_\_yes\_\_ no  
Leave a message at your place of employment? \_\_yes\_\_ no  
Talk with a family member about your condition? \_\_yes\_\_ no

***If patient is a minor, please fill out the following:***

Responsible Parent/ Guardian \_\_\_\_\_ SS# \_\_\_\_\_  
Address \_\_\_\_\_ DOB \_\_\_\_\_  
Employer \_\_\_\_\_ Phone # \_\_\_\_\_

**INSURANCE INFORMATION:**

**Name:** \_\_\_\_\_  
**Policy#:** \_\_\_\_\_  
**Group#** \_\_\_\_\_  
**Insured's Name** \_\_\_\_\_  
**Insured's SS#** \_\_\_\_\_  
**Insured's Date of Birth:** \_\_\_\_\_  
**Insured's Employer:** \_\_\_\_\_

**Secondary Policy:**

**Name:** \_\_\_\_\_  
**Policy#:** \_\_\_\_\_  
**Group#** \_\_\_\_\_  
**Insured's Name** \_\_\_\_\_  
**Insured's SS#** \_\_\_\_\_  
**Insured's Date of Birth:** \_\_\_\_\_  
**Insured's Employer:** \_\_\_\_\_

**Consent for Treatment and Release of Medical Information:**

I authorize treatment and/or services to myself or minor child at Azalea Coast Plastic Surgery, PA. I authorize the release of my medical records to my primary care, and/ or referring, and/or consulting physician as needed, and as necessary to process insurance claims and prescriptions. I also authorize payment of medical benefits to Azalea Coast Plastic Surgery, PA.

Signed: \_\_\_\_\_  
*Patient or Responsible Party*

Date: \_\_\_\_\_

**Payment Agreement:**

I agree to pay my deductibles , co-payments, and payments at the time services are rendered. We accept cash, checks, and Visa/ MasterCard/ Discover.

Signed: \_\_\_\_\_  
*Patient or Responsible Party*

Date: \_\_\_\_\_