PLASTIC SURGERY ASSOCIATES OF MONTGOMERY, P. C.
PATIENT INFORMATION SURVEY

Date of Appointment: ____________________________

Patient Name: ____ Home Phone_____________
First Middle Last

Address: ____ Work Phone: ________________

City:____________________________ State:_________ Zip Code:_________________ Cellular Phone:_______________

Social Security #:_____________________ Date of Birth:__________________ Marital Status:____________ Sex:_______

Employer: ____Occupation:___________________________________

E-mail address:____ May we contact you through e-mail? ____Yes ____No

Referring Doctor:___________________________ Accident Date (if applicable): ____________Type: Home – Work - Auto

Emergency contact:______________________________________ Phone #:_______________ Relationship to you:_______

Primary Insurance Company:
____

Primary Company's
Address For Filing Claims: ____-__________________

Primary Company's
Telephone Number For Claims:
____

Named Insured: ____ Relation to patient: _____________________

Insured's Date Of Birth: _____________________________________ Policy Or Contract #:___________________________

Group Name and Number:_____________
____

Secondary Insurance Company:____

Secondary Claims Telephone Number:_____________________________ Secondary Insured's Date of Birth:_____________

Secondary Insured's Name:____ Relation to patient:______________________

Secondary Group Number:____ Policy Number:________________________

Please initial the following statements:

______ I herewith authorize the release of any medical information necessary to process my claim.

______ I herewith assign insurance and other payments for surgical /medical services to Plastic Surgery Associates Of Montgomery, P. C.

REGARDLESS OF INSURANCE COVERAGE, I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR THE PAYMENT OF ALL CHARGES INCURRED FOR SERVICES RENDERED TO ME OR THE PATIENT NAMED ABOVE.

Signature: _____________________________________ Date: ___________________________