

PATIENT INFORMATION
(PLEASE PRINT)

PATIENTS _____ DATE _____

NAME _____ BIRTHDATE _____ SEX _____ AGE _____

STREET _____ CITY _____ STATE _____ ZIP _____

HOME _____ WORK _____ CELL _____

MARITAL STATUS _____ IF MINOR, PARENTS NAMES _____

E-MAIL ADDRESS _____ PREFERRED CONTACT METHOD _____

■ **FINANCIAL INFORMATION**

PATIENTS EMPLOYER _____ OCCUPATION _____

ADDRESS _____ SOCIAL SECURITY NO _____

PARENT/SPOUSE NAME _____ SOCIAL SECURITY NO _____

PARENT/SPOUSE EMPLOYER _____ OCCUPATION _____

ADDRESS _____ WORK PHONE _____

■ **INCASE OF EMERGENCY**

NEAREST RELATIVE _____ RELATIONSHIP _____

ADDRESS _____ PHONE _____

■ **INSURANCE INFORMATION**

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____

ADDRESS _____ ADDRESS _____

INSURED _____ INSURED _____

NAME ON ID CARD _____ NAME ON ID CARD _____

DATE OF BIRTH _____ DATE OF BIRTH _____

RELATIONSHIP TO PATIENT _____ RELATIONSHIP TO PATIENT _____

INSURED ID NO _____ INSURED ID NO _____

GROUP # OR CO. NAME _____ GROUP # OR CO. NAME _____

EFFECTIVE DATE _____ EFFECTIVE DATE _____

■ **REFERRED BY**

DOCTOR _____ PHONE _____

FRIEND/RELATIVE _____ OTHER _____

COMPLETE BACK OF FORM

HEALTH QUESTIONS

PERSONAL PHYSICIAN _____ CITY _____

IS YOUR GENERAL HEALTH GOOD? _____

LIST CURRENT MEDICATIONS - PRESCRIPTION AND NON-PRESCRIPTION (with dosages) _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? _____ ALLERGIC TO LATEX? _____

LIST ANY PRIOR SURGERIES _____

LIST KNOWN MEDICAL PROBLEMS _____

DO YOU HAVE A TENDENCY TO BLEED? Y N DO YOU TAKE ASPIRIN? Y N

DO YOU USE TOBACCO? Y N DO YOU DRINK ALCOHOL? Y N

In order to submit a claim for payment to use for service covered under your policy, we must have your authorization to release medical information to your carrier.

COMMERCIAL INSURANCE

I HEREBY AUTHORIZE RELEASE ON INFORMATION NECESSARY TO THE FILE CLAIM WITH MY INSURANCE COMPANY AND ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE DOCTOR OR GROUP INDICATED ON THE CLAIM.

CONCERNING YOUR BILL

Patients who carry Health Care Insurance should remember that professional services are rendered and charged to the patient and not to the Insurance Company.

Many Medical Insurance Policies provide incomplete coverage for your medical expenses. Your medical insurance may pay only a small part of your bill. You would be responsible for the remainder of the bill.

This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlements on a dispute claim; however, we will be happy to assist, in any way possible, the processing of our claim

I understand I am financially responsible for any balance not covered by my insurance carrier.

Should provider of service be required to employ an outside service to collect any unpaid balance, I agree to pay all costs, a fee of 1/3 the balance, and a financial charge of 1 1/2% per month from the date of service. Refunds for credit card payments are charged 4% service charge.

In the interest of better medical diagnosis and treatment, I authorize East Tennessee Plastic Surgery, P.C., to take any photographs as adjuncts to diagnosis and/or treatment.

Signature

Date

MEDICARE

Name of Beneficiary _____ Medicare # _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to East Tennessee Plastic Surgery, P.C., for any services furnished me by these physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I hereby authorize Medicare to furnish to the above named doctor any information regarding my Medicare claims under Title XVIII of the Social Security Act.