South Bay Plastic Surgeons

# PATIENT INFORMATION FORM

Name______________________________________________

Date of Birth ______________________ Gender______________

SS# ______________-______________-________________

Address ___________________________________________

City _______________________ State______ Zip____________

Phone #: Home _______________________________

Cell________________________________

Work _______________________Ext__________

E-mail address _________________________________

❑ Please contact me regarding monthly specials

Employer ___________________________________________

Employer's Address __________________________________

City _______________________ State _____ Zip ____________

**Person Responsible for Bill (complete in full or ❑ same as above)**

❑ Self ❑ Spouse ❑ Employer ❑ Guardian ❑ Parent

Name ______________________________________________

Social Security Number _________________________________

Date of Birth ________________________________________

Address _______________________ ____________________

Phone # _____________________ ____________________
home work

Employer ___________________________________________

Employer's Address __________________________________

### Photography Consent

*I authorize the physician or his/her assistant to take digital photographs. These photographs are the doctor's property. The photographs will be a permanent part of the record and they will be used for surgical, office, and insurance purposes. The photographs may be used for teaching, lectures, educational conferences, or medical journals.*

Signature ____________________________ Date ____________

### Authorization for Payment/Release of Medical Records

*I authorize release of medical records and payment of benefits to the physician and allow a photocopy of my signature to be used to file insurance. I understand that my insurance may not cover all fees and services provided and I will be responsible for the unpaid balance.*

Signature _____________________________ Date ___________

### Referral:

❑ Doctor ❑ Patient ❑ Friend ❑ Internet ❑ Other

Physician's Name ____________________________________

Patient's/Friend's Name_________________________________

Website ___________________________________________

Other _____________________________________________

### Primary Care Physician (complete in full)

Physician's Name ____________________________________
first last

Address ___________________________________________

City ___________________ State ______ Zip ____________

Phone _____________________________________________

### Person to contact in case of emergency

Name ____________________ Relationship _______________

Phone #: Home ___________________________________

Cell____________________________________

Work ______________________Ext__________

### Acknowledgement of Receipt of Notice of Privacy Practices

**Notice to Patient**: We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Your signature on this form acknowledges your receipt of the Notice.

I acknowledge that I have received a copy of the Association of South Bay Plastic Surgeons' Notice of Privacy Practices.

Signature ________________________ Date __________

Charles W. Spenler, MD Michael K. Newman, MD Lisa L. Jewell, MD

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