



LISA L. JEWELL, M.D. · MICHAEL K. NEWMAN, M.D. · CHARLES W. SPENLER, M.D.

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 _____

Address _____

City _____ State _____ Zip _____

Phone # _____

home

work

Employer _____

Employer's Address _____

Photography Consent

I authorize the physician or his/her assistant to take photographs. The term "photograph" includes Polaroid, 35m., standard photographs, videotape, digital, etc. These photographs are the doctor's property and will be a permanent part of the record and will be used for surgical/office/insurance purposes. They may be used for teaching, lectures, educational conferences or publication.

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 _____

Insurance Information

My plan is a: PPO HMO POS (Point of Service) other

Patient's relationship to responsible party:

self spouse child guardian other

Primary Insurance _____

Name of Insured _____ Birthdate _____

Member ID# _____ Group # _____

Secondary Insurance _____

Name of Insured _____ Birthdate _____

Member ID# _____ Group # _____

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 _____