PATIENT INFORMATION FORM

Name_____

Date of Birth _____ Gender_____

SS# _____-_____-_____

Address _____

City _____ State_____ Zip_____

E-mail address _____

Phone # (please check preferred phone number for contact):

- ❑ Home _____
- ❑ Cell_____
- ❑ Work _____Ext_____

Employer _____

How would you like us to contact you regarding your upcoming appointments?

❑ Email
❑ Text Message
If you selected text message above, please select your current cellular phone company:
❑ Verizon ❑ AT&T ❑T-Mobile
❑ Other _____

What is your pharmacy information?

Name _____

Phone #:_____

Address_____

What is your Race/Ethnicity (Check all that apply):

☐ Hispanic or Latino ☐ Black or African American
☐ Asian ☐ White/Caucasian
☐ American Indian/Alaska Native
☐ Native Hawaiian/Other Pacific Islander
☐ Other/Unknown:_____

Who should we contact in the case of an emergency?

Name _____ Relationship _____

Phone #: Cell_____

Work _____Ext_____

Home_____

Primary Care Physician (complete in full)

Physician's Name _____
first last

City _____

Phone _____

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.

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 _____

Acknowledgement of Notice of Privacy Practices

Notice to Patient: We are required to inform you of our Privacy Practices, which states how we may use and/or disclose your health information. Our Notice of Privacy Practices is posted in the waiting room in our office for you to review. A copy of the Notice is available to you upon request at any time. Your signature on this form acknowledges that you have access to this Notice.

I acknowledge that I have received information regarding South Bay Plastic Surgeons' Privacy Practices.

Signature _____ Date _____

Financial Agreement

In order to prevent any misunderstanding we wish to point out:

1. Your insurance coverage is a contract between you and your insurance company to help you meet medical expenses. It is not possible for us to provide services on the basis that your insurer will always pay 100% of your care. You are financially responsible for your deductible, copay and coinsurance.
2. All balances must be paid within 90days of invoicing or your account will be sent to collections and you will be responsible for attorney and collections fees.
3. By signing below you acknowledge you have read and understand this agreement and you authorize the release of information necessary to process claims.

I acknowledge that I have received information regarding South Bay Plastic Surgeons financial practices.

Signature _____ Date _____