CHEGAR FACIAL PLASTIC SURGERY

PATIENT INFORMATION

NAME: _____ **DATE:** _____
LAST FIRST MI

DATE OF BIRTH: _____ **AGE:** _____ **SEX:** ___ **HEIGHT:** _____ **WEIGHT:** _____ **SSN:** ___ - ___ - ____
MARITAL STATUS: [ ] MARRIED [ ] SINGLE [ ] OTHER

ADDRESS: _____
STREET CITY STATE ZIP

HOME PHONE: _____ **WORK PHONE:** _____ **MOBILE PHONE:** _____

E-MAIL: _____

PHARMACY PHONE and/or LOCATION: _____

HOW DID YOU HEAR ABOUT US? (Check all that apply)

[ ] PHYSICIAN REFERRAL: _____ [ ]FRIEND: _____ [ ] WEBSITE: _____

[ ] ADVERTISING/PUBLICATION: _____ [ ] OTHER: _____

IN CASE OF EMERGENCY, PLEASE LIST NAME, PHONE NUMBER AND RELATIONSHIP OF PERSON(S) TO CONTACT:

NAME: _____ PHONE: _____ RELATIONSHIP: _____
NAME: _____ PHONE: _____ RELATIONSHIP: _____

REFERRING PHYSICIAN: _____ **PHONE:** _____
FAMILY PHYSICIAN: _____ **PHONE:** _____

INSURANCE INFORMATION

ARE YOU THE SUBSCRIBER FOR YOUR PRIMARY INSURANCE ?

[ ]YES [ ] NO, Subscriber Name: _____ **DOB:** _____ **SSN:** ___ - ___ - ____

ARE YOU THE SUBSCRIBER FOR YOUR SECONDARY INSURANCE ?

[ ]YES [ ] NO, Subscriber Name: _____ **DOB:** _____ **SSN:** ___ - ___ - ____

***Please provide a valid photo ID and insurance card(s) to be copied for policy information details.**

IS PATIENT RESPONSIBLE FOR THE BILL? [ ]YES [ ] NO-RESPONSIBLE PARTY/RELATIONSHIP: _____

BILLING ADDRESS: _____

I hereby authorize release to the above named insurance company(s) any medical information necessary to process any of my insurance claims or the release of any facts concerning the treatment provided. I further authorize the above insurance company(s) to pay direct to Northside ENT, Inc. the medical benefits otherwise payable to me. I understand that I am financially responsible for those charges not paid by my insurance. Also, I certify that all of the above health insurance plan(s) do/do not require preauthorization and/or a second opinion in connection with services to be provided.

SIGNATURE: _____ **DATE:** _____
RESPONSIBLE PARTY/PARENT/LEGAL GUARDIAN