# 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:** _____

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**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: _____

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

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

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**PRIMARY INSURANCE:** _____ **POLICY #:** _____ **GROUP #:** _____

**ARE YOU THE SUBSCRIBER FOR YOUR PRIMARY INSURANCE ?**

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

**SECONDARY INSURANCE:** _____ **POLICY #:** _____ **GROUP #:** _____

**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