



PLASTIC SURGERY
• CENTER •

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other _____

Age _____ Birthdate _____ SS# _____ - _____ - _____ Sex Female Male

Marital Status Single Spouse _____ Other _____

Would you like to receive our monthly specials and promotions Via E-mail? Yes No

E-mail address _____

How were you referred to our office? Television Radio Wichita Eagle Women's Focus Splurge E-mail

Facebook Twitter Women's Fair Friend/Patient: _____

Website: _____ Phonebook: _____

Doctor: (full name) _____ Other: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? Yes No

Emergency Contact _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

If a patient is a minor child, please list both parents names: _____

Please select if: **WORKERS COMP** **AUTO ACCIDENT** **DATE OF ACCIDENT** _____

Primary Ins. _____ **Insured Parties (Full name)** _____

Employer _____ DOB _____ SS# _____

Relationship to patient _____ Group# _____ Policy # _____

Secondary Ins. _____ **Insured Parties (Full name)** _____

Employer _____ DOB _____ SS# _____

Relationship to patient _____ Group# _____ Policy # _____

Consent to Taking Photographs

I hereby authorize Plastic Surgery Center to take photographs of me under the following conditions. The photographs will include only the necessary body parts to identify the area to be treated. **These photographs shall be used for documentation only.** These photographs shall become the property of the Plastic Surgery Center and shall not be disclosed to anyone (other than as above provided), except as required by law.

Signature _____ **Date** _____

Assignment of Benefits and Release of Information

I understand that I am financially responsible for any non-covered services, usual & customary charges, co pays & deductibles not covered by my insurance (COPAYS ARE DUE ON DATE OF SERVICE) and I hereby assign my insurance benefits to be paid directly to the Plastic Surgery Center. **I acknowledge that I am responsible for any referral that my insurance may require and I have checked to make sure the physician is in my plans network.** I also authorize the provider to release any information required to process the claim. I agree that this office may release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges. Information may be released to any provider involved in my medical care (by fax or mail).

Signature _____ **Date** _____