

PLASTIC SURGERY — OF WESTCHESTER —

Patient Demographics

Today's Date _____

Last Name _____ First Name _____ MI _____

Date of Birth _____ Age _____ Gender: Female Male

Address _____ Apt. # _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____

E-mail _____ Instagram _____

Marital Status Single Married Divorced Separated Widowed Minor Partnered

Employer: _____ Occupation: _____

How did you hear about us? _____

Emergency Contact: _____ Phone: _____

Pharmacy

Name of Pharmacy _____ Telephone Number _____

Address _____ City _____ State _____

Insurance

Insurance Carrier Name: _____ Insurance Phone # _____

Insurance ID # _____ Group Number: _____

Primary Care Doctor Information

Primary Care Physician Name _____ Phone _____

Practice Name _____

Address _____ City _____ State _____ Zip _____

I certify that I, and/or my dependent(s), are aware provider is out-of-network with my insurance plan. I have active insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature _____ Print Name _____ Date _____