

**PLASTIC SURGERY SPECIALISTS
PLEASE PRINT**

New Patient Update Date _____

Chart Number _____ Email _____ Dr. _____

Name of Patient _____
Last First Middle

Date of Birth _____ Age _____ Social Security # _____

Home Address _____
Street City State Zip Code

Home Telephone # _____ Business # _____ Cell # _____

Patient Employed By _____ Occupation _____

Name of Spouse/Parent/Guarantor _____ Daytime Phone # _____

Name of Insurance Carrier _____

Policyholder Name _____ Date of Birth _____ Insured ID # _____

Policyholder Employed By _____ Business Phone _____

Name of Secondary Insurance Carrier _____

Policyholder Name _____ Date of Birth _____ Insured ID # _____

Has patient ever been seen by one of our physicians? Yes No / (Which one?) Lowe Buhrer Spittler

Who is your Primary Care Physician (PCP)? _____ Office Phone _____

Reason for today's visit _____ Referred By _____ Phone # _____

Is this visit due to an injury? Yes No Injury Date _____ Was this a work related injury? Yes No

Party Responsible for Payment of Account _____

I hereby authorize payment directly to Plastic Surgery Specialists, P.C. for the surgical and/or medical benefits, if any, otherwise payable to me under the terms of my insurance.

In the event it becomes necessary to forward your account for collection action due to nonpayment, the undersigned hereby agrees to pay 1% interest, per month, on all past due balances, attorney's fees of 33.3%, all court costs, and any additional charges for obtaining and verifying credit information during the collection of this account.

Date Patient/Insured's Signature Witness

Update Signature Date Update Signature Date

PLEASE PRESENT YOUR HEALTH INSURANCE CARD AND DRIVERS LICENSE TO THE RECEPTIONIST