

PATIENT INFORMATION

Patient Name

_____ **Age** _____ **Birthdate** _____
Last first middle

Address _____ **Social Security No.** _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail Address _____

Sex M ___ F ___ Child Single Divorced Married Widow

Patient's Employer _____ Occupation _____

Referred by: Physician _____ Physician Phone Number _____

Previous Patient _____ Internet Yellow Pages Health Facility Other _____

Reason for visit _____

Emergency Contact _____ **Phone** _____

Last First Relationship

Responsible Party

Legal Name _____ Spouse _____

Mr. Mrs. Ms. Last first middle

Address _____

Street city state zip

Relationship to patient _____ Employer _____

SS# _____ **Phone**(home) _____ (work) _____

Work related Yes No **Date of Injury** _____

Insurance Company Information

Primary Insurance _____

Secondary _____

Medicare Primary Yes No (Circle one)

RELEASE INFORMATION:

I certify that the information I have reported with regard to my insurance carrier is correct. I authorize the release of any necessary information, including medical information to my Insurance Carrier Attorney, Physician, Hospital, Medicare or other Medical Facility.

Signature

Date

ASSIGNMENT OF BENEFITS:

I request the payment of benefits(Medicare, Medicaid, or other insurance, carrier)be made directly to Bajaj Plastic Surgery for services furnished to me by P.S. Bajaj, MD or Anureet Bajaj, MD. I authorize Bajaj Plastic Surgery to apply for benefits on my behalf.

Signature

Date