PARKWAY PLASTIC SURGERY

(904) 396-1186

Patient Information as of ___________

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name: ______________________________
Last First Middle

Address: ______________________________
Street & Apt # City State Zip

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

Any restrictions for contacting you? ❐ No ❐ Yes Contact Restrictions: ____________

Sex: ❐ Female ❐ Male E-mail: ____________

Age: ______ Birthdate: ________ Social Security #: ____________

Marital Status: ❐ Single ❐Married ❐Other: ________ Married to: ____________

Patient's Employer: ____________ Occupation: ____________

Spouse's Employer: ____________ Occupation: ____________

Emergency Contact: ____________ Relationship to Patient: ____________

Home Phone: ________ Work Phone: ________ Other Phone: ________

Pharmacy Name: ____________ Phone: ____________

Address: ______________________________
Street City State Zip

Primary Health Insurance Company: ____________

Policy No: ________ Group#: ________ Patient Relationship to Insured: ________

Subscriber /Insured Name: ________ DOB: ________ Social Security #: ________

Secondary Health Insurance Company: «Secondary_Ins_Co_Name»

Policy No: ________ Group#: ________ Patient Relationship to Insured: ________

Subscriber/Insured Name: ________ DOB: ________ Social Security #: ________

Primary Physician: ____________ Office Phone: ________

Referring Physician: ____________ Office Phone: ________

I understand that services are rendered to me, not the insurance company. Therefore, payment for services are my responsibility. I authorize this office to release or receive any information necessary to expedite my insurance claim. I authorize this office to bill my insurnace company directly for my services. I authorize payment directly to this practice for any insurance benefits otherwise payable to me. In the event that I receive payment from my insurance company, I agree to endores any payment I receive over to my physician for which these fees are payable. I understand that I am directly and fully responsible to this practice for charges not covered by my insurance. I understand that such payments is not contingent on any settlement, judgement or insurance payment by which I eventually recover. I realize that if my insurance company fails to pay my balance in full, or there is no payment made within 60 days, it is my responsibility to pay my bill. I further understand that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collections. I undertand thereis a $25 charge on all returned checks.

Signature: ______________________________ **Date:** ____________