

southeastern plastic surgery, p.a.

TODAY'S DATE:

PATIENT NAME			NICKNAME	SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D
DATE OF BIRTH	AGE	RACE	HOME PHONE NUMBER ()		SOCIAL SECURITY #
EMAIL ADDRESS			WORK PHONE NUMBER ()		CELL PHONE NUMBER ()
ADDRESS			CITY	STATE	ZIP CODE
EMPLOYER (Company Name)			JOB TITLE or RETIREMENT DATE		
EMPLOYER ADDRESS			CITY	STATE	ZIP CODE
REFERRING DOCTOR			NAME FAMILY PHYSICIAN		PHONE NUMBER

RESPONSIBILITY PARTY

NAME		RELATIONSHIP	SOCIAL SECURITY #		
ADDRESS		CITY	STATE	ZIP CODE	
EMPLOYER (Company Name)		JOB TITLE			PHONE NUMBER (H)
ADDRESS		CITY	STATE	PHONE NUMBER (W)	

INSURANCE INFORMATION

PRIMARY INSURANCE		ID #	GROUP #	PHONE NUMBER
POLICY HOLDERS NAME		DATE OF BIRTH	SOCIAL SECURITY #	
AUTHORIZATION OR REFERRAL NUMBER		DATE AUTHORIZED	AUTHORIZED BY	
SECONDARY INSURANCE		ID#	GROUP #	PHONE NUMBER
POLICY HOLDERS NAME		DATE OF BIRTH	SOCIAL SECURITY #	
AUTHORIZATION OR REFERRAL NUMBER		DATE AUTHORIZED	AUTHORIZED BY	

HAVE YOU EVER BEEN A PATIENT AT/OF: DR. KIRBO DR. ROSENBERG TMH TCH TSDS

WAS YOUR INJURY WORK RELATED? YES NO DATE OF INJURY:

WAS YOUR INJURY WORK RELATED? YES NO DATE OF INJURY:

IF WORKERS COMPENSATION OR AUTO INSURANCE, PLEASE COMPLETE THE FOLLOWING:

WORKERS COMPENSATION CARRIER OR AUTO CARRIER		DATE OF INJURY
CLAIM #	ADJUSTER NAME	PHONE NUMBER

SURGERY INFORMATION

<input type="checkbox"/> OFFICE <input type="checkbox"/> SEOPSC <input type="checkbox"/> MAIN OR <input type="checkbox"/> TMHOS <input type="checkbox"/> TSDS			<input type="checkbox"/> INSURANCE <input type="checkbox"/> SELF PAY		
			<input type="checkbox"/> AM ADMIT <input type="checkbox"/> OUTPATIENT <input type="checkbox"/> INPATIENT		
MEDICAL DIAGNOSIS				ICD 9 CODE	
SURGICAL DIAGNOSIS				CPT CODE	
PRE-OP DATE	PRE-OP TIME	SURGERY DATE	SPECIAL EQUIPMENT		
TYPE OF ANESTHESIA <input type="checkbox"/> GENERAL <input type="checkbox"/> MAC <input type="checkbox"/> LOCAL <input type="checkbox"/> CHOICE			GROUP <input type="checkbox"/> AAT <input type="checkbox"/> CCA <input type="checkbox"/> TAA		OR TIME
			OTHER		

EMERGENCY INFORMATION AND NEXT OF KIN

Name _____ Phone # _____ (work) _____ (home)

Relationship to patient _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO:

As part of your medical care, there are times when medical information will need to be released to a 3rd party - such as your family or primary care physician. If testing is ordered - medical / personal demographic information will need to be released for continuity of care. We at Southeastern Plastic Surgery respect your right for privacy and confidentiality of your medical information. Your medical information will only be released for us to be able to provide continuity of care. If you wish for others to have permission to receive from us information regarding your test results or medical history (such as family members/spouses) please provide the following information for us below:

This authorization allows Southeastern Plastic Surgery to release medical information to:

Name Relationship Date of Birth

Name Relationship Date of Birth

I may revoke this at anytime, by notifying Southeastern Plastic Surgery in writing of such changes. This will be made a part of my medical record.

Referring Physician: _____ Family Physician: _____

How did you hear about us?

- "Hot Ten Topic" Radio Phone Book Friend (Name) _____
- Bridal Show Newspaper Internet Doctor (Name) _____
- Magazine Lecture Web Site Patient (Name) _____

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Southeastern Plastic Surgery. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNED _____ DATE _____