PATIENT INFORMATION

Patient Name

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

Address_____**SocialSecurityNo**._____

City_____State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

E-mail Address _____

Sex M____F____ Child Single Divorced Married Widow

Race _____ Ethnicity _____ Language_____

Patient's Employer_____Occupation_____

Reason for visit_____

_____

Referred by: Physician_____ Physician Phone Number _____

Previous Patient_____ Internet Yellow Pages Health Facility Other_____

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_____

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