PLASTIC SURGERY ASSOCIATES OF MONTGOMERY, P. C.
PATIENT INFORMATION SURVEY

Date of Appointment: _____

Patient Name: _____ Home Phone_____
First Middle Last

Address: _____ Work Phone: _____

City:_____ State:_____ Zip Code:_____ Cellular Phone:_____

Social Security #:_____ Date of Birth:_____ Marital Status:_____ Sex:_____

Employer: _____Occupation:_____

E-mail address:_____ May we contact you through e-mail? ____Yes ____No

Referring Doctor:_____ Accident Date (if applicable): _____Type: Home – Work - Auto

Emergency contact:_____ Phone #:_____ Relationship to you:_____

Primary Insurance Company: _____
Primary Company's
Address For Filing Claims: _____
Primary Company's
Telephone Number For Claims: _____

Named Insured: _____Relation to patient: _____

Insured's Date Of Birth: _____ Policy Or Contract #:_____

Group Name and Number:_____ _____

Secondary Insurance Company:_____

Secondary Claims Telephone Number:_____ Secondary Insured's Date of Birth:_____

Secondary Insured's Name:_____ Relation to patient:_____

Secondary Group Number:_____ Policy Number:_____

Please initial the following statements:

_____ I herewith authorize the release of any medical information necessary to process my claim.

_____ I herewith assign insurance and other payments for surgical /medical services to Plastic Surgery Associates Of Montgomery, P. C.

REGARDLESS OF INSURANCE COVERAGE, I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR THE PAYMENT OF ALL CHARGES INCURRED FOR SERVICES RENDERED TO ME OR THE PATIENT NAMED ABOVE.

Signature: _____ Date: _____