LAKE COUNTRY PLASTIC AND HAND SURGERY
PATIENT INFORMATION

Patient Name:_____ Date:_____

Parent/ Legal Guardian Name:_____

Address:_____ City/State/Zip:_____

Phone:_____ Email: _____

Date Of Birth:_____ Age:_____ Gender:_____

Driver's License #:_____ SSN:_____

Marital Status:_____Name of Spouse:_____

How did you hear about us?_____

Emergency Contact:_____Relationship:_____

Home Phone:_____ Cell Phone:_____

Address:_____City/State/Zip:_____

Patient's Employer (Or legal guardian if a minor):_____

Full time or Part time

Address:_____ City/State/Zip:_____

Insured's Name:_____ Subscribers Name: _____

Relationship to Patient:_____ Subscribers Birthdate:_____

Subscribers Employer:_____

Are you a member of the armed forces?_____

If yes, are you currently on active duty?_____

I authorize the physician to release any information required in the course of my treatment and permit the payment directly to her of any benefits due for services rendered. I recognize and accept responsibility for any balance remaining after payment or no payment of such benefits. I also understand if my insurance carrier requires a referral, second opinion or pre-authorization I am responsible. Failure may result in my insurance carrier denying my claim and I will be responsible for any balance resulting if this occurs.

Patient/Responsible Party:_____ Date:_____