

Date _____

Chart Number _____

PATIENT INFORMATION

First	M.I	Last		(N	lick Name)	
Date of Birth	Age	Marital Status	s	Ge	ender □ Male	□ Female
Address		City		State	ZIP	
SS#	Em	ail Address				
Primary Phone	₽	Home □ Cell Secor	ndary Phone		₽⊦	lome □ Cell
How would you like us to comm Appointment Reminders			<mark>iat apply:</mark> Phone (Home / Cell)) Place (Circlo Ono	
Monthly Specials and Discou		Email 🗖 Text				
Montiny opecials and Discou						
<u>Employe</u> r		Оссира	ation	Pho	one	
Emergency ContactName		Relationship	p	Ph	one	
Referring Dr		Ph	none			
Primary Dr		Ph	one			
How did you hear about our offi	ce?					Name of person
who referred you					_	
				ooro profoo	sional in this facili	
mucous membrane, or open wound exp	osure to blood	or other body fluids from	n myself that an HIV and	Hepatitis-B	(HBV) blood test	will be performed.
Signature	posure to blood	or other body fluids from	n myself that an HIV and	Hepatitis-B <mark>e</mark>	(HBV) blood test	will be performed.
mucous membrane, or open wound exp Signature INSURANCE & BILLING IN	FORMATIC	or other body fluids from	n myself that an HIV and Date if you don't have	Hepatitis-B e insuran	(HBV) blood test	will be performed.
mucous membrane, or open wound exp Signature INSURANCE & BILLING INI <u>Primary Insurance</u>	FORMATIC	or other body fluids from	n myself that an HIV and Date if you don't have riber	Hepatitis-B e e insuran	(HBV) blood test	will be performed.
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mucous membrane, or open wound exp Signature INSURANCE & BILLING INI <u>Primary Insurance</u> Specialist Copay \$ 0	FORMATIC FORMATIC Group Numb directly to Gran stand that I am pree to pay all s equired to proc ked by me in wr	or other body fluids from ON—Fill this out i Subscr erSubsc exSubsc exSu	n myself that an HIV and Date if you don't have riberPolicy Number criberPolicy Number ry, PC. I also request pa or any services or materia nless a payment plan is in formation deemed neces Date Practices detailing	Hepatitis-B e insuran ayment of go als not cove negotiated i ssary by the g how my	(HBV) blood test ice card with red by my insuran n advance. I auth e doctor to be ser	will be performed.
mucous membrane, or open wound exp Signature INSURANCE & BILLING INI Primary Insurance Specialist Copay \$	FORMATIC FORMATIC Group Numb Group Numb directly to Gran stand that I am pree to pay all s equired to proc and by me in wr copy of the nder federa	or other body fluids from ON—Fill this out i Subscr erSubscr erSubsc er	n myself that an HIV and Date if you don't have riber Policy Number criber Policy Number ry, PC. I also request pa or any services or materia nless a payment plan is in formation deemed nece Date Practices detailing d outlining my righ	Hepatitis-B e insuran ayment of go als not cove negotiated i essary by the g how my nts regarc	(HBV) blood test ace card with wernment benefit red by my insurar n advance. I auth a doctor to be ser y health infor ling my healt	will be performed.
mucous membrane, or open wound exp Signature INSURANCE & BILLING INI Primary Insurance Specialist Copay \$C Secondary Insurance Specialist Copay \$C I authorize payment of medical benefits party who accepts assignment. I unders deductible or co-payment amounts. I ac release any information and/or photos r request shall remain in effect until revole Signature I have been presented with a and disclosed as permitted un Signed:	FORMATIC FORMATIC Group Numb Group Numb directly to Gran stand that I am gree to pay all s equired to proc sed by me in wr copy of the nder federa	or other body fluids from ON—Fill this out i Subscr erSubscr erSubscr erSubscr erSubscr erSubscr ind Rapids Plastic Surger financially responsible fo ervices within 30 days u ess my claim, and any in iting. Notice of Privacy I and state law anceRe	if you don't have if you don't have riber Policy Number policy Number ry, PC. I also request pa prany services or materia nless a payment plan is in formation deemed neces Date Practices detailing d outlining my righ elationship (if not sig	Hepatitis-B e insuran ayment of go als not cove negotiated i essary by the g how my nts regarc	(HBV) blood test ace card with wernment benefit red by my insurar n advance. I auth a doctor to be ser y health infor ling my healt	will be performed.
mucous membrane, or open wound exp Signature INSURANCE & BILLING INI Primary Insurance Specialist Copay \$	FORMATIC FORMATIC Group Numb Group Numb directly to Gran stand that I am pree to pay all s equired to proc aced by me in wr copy of the nder federa Date c Surgery, P	or other body fluids from ON—Fill this out i Subscr erSubscr erSubsc er	if you don't have if you don't have riber Policy Number riber Policy Number ry, PC. I also request pa or any services or materia nformation deemed nece Date Practices detailing d outlining my righ elationship (if not sig records to: Relationship	Hepatitis-B insuran insuran ayment of go als not cove negotiated i issary by the g how my ots regarc gned by pa hip:	(HBV) blood test	will be performed.