Date _____

Chart Number _____

PATIENT INFORMATION

*First*_____ *M.I.* _____*Last*_____ *(Nick Name)*_____

*Date of Birth*_____ *Age* _____ *Marital Status*_____ *Gender* ☐Male ☐Female

*Address*_____*City*_____*State*_____*ZIP*_____

*SS#*_____ *Email Address* _____

*Primary Phone*_____ ☐Home ☐Cell *Secondary Phone*_____ ☐Home ☐Cell

How would you like us to communicate with you? Choose all that apply:

Appointment reminders ☐ Email ☐ Text ☐Phone (Home / Cell) *Please Circle One*

Provider follow up communication ☐ Email ☐ Text ☐Phone (Home / Cell) *Please Circle One*

Monthly specials and discounts ☐ Email ☐ Text

Employer _____ *Occupation* _____ *Phone*_____

*Emergency Contact--Name*_____*Relationship*_____*Phone*_____

Referring Dr. _____*Phone*_____

*Primary Dr*_____*Phone*_____

How did you hear about our office? _____

Name of person who referred you _____

I understand according to the State of Michigan, Department of Health, Act 488 of 1988 that if a health care professional in this facility sustains a cutaneous, mucous membrane, or open wound exposure to blood or other body fluids from myself that an HIV and Hepatitis-B (HBV) blood test will be performed.

Signature_____Date_____

INSURANCE & BILLING INFORMATION—Fill this out if you don't have insurance card with you

Primary Insurance_____Subscriber_____

Specialist Copay $_____ Group Number_____ Policy Number_____

Secondary Insurance_____Subscriber_____

Specialist Copay $_____ Group Number _____ Policy Number_____

I authorize payment of medical benefits directly to Grand Rapids Plastic Surgery, PC. I also request payment of government benefits either to myself or to the party who accepts assignment. I understand that I am financially responsible for any services or materials not covered by my insurance and for any yearly deductible or co-payment amounts. I agree to pay all services within 30 days unless a payment plan is negotiated in advance. I authorize the physician to release any information and/or photos required to process my claim, and any information deemed necessary by the doctor to be sent via fax transmission. This request shall remain in effect until revoked by me in writing.

Signature _____Date_____

I have been presented with a copy of the Notice of Privacy Practices detailing how my health information may be used and disclosed as permitted under federal and state law and outlining my rights regarding my health information.

Signed: _____ Date: _____Relationship (if not signed by patient): _____

I authorize Grand Rapids Plastic Surgery, PLC, to disclose my health information to:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Internal Use Only
Presented on (date and time): _____