deRamón
PLASTIC SURGERY INSTITUTE, P.C.

PATIENT INFORMATION – Please Print

Patient's Last Name	First		M.I.	Date of Birth Age
Street Address			Apt.#	Social Security #
City	State	Zip Code		Marital Status M S D W Other
Home Phone	Work Phone	Alternate Phone		Gender M F
Patient's Occupation	Employer's Name	Family Physician/Phone		
Person to Notify in Emergency (Name and Phone#)		Referred By		

INSURANCE – Please present your insurance card to the receptionist

Insurance Company Name and Address			
Identification #	Group #	Effective Date	
Policy Holders Name and Address		SS#	Date of Birth

SECONDARY INSURANCE – Please present your insurance card to the receptionist

Insurance Company Name and Address			
Identification #	Group #	Effective Date	
Policy Holders Name and Address		SS#	Date of Birth

I consent to treatment necessary for the care of the above patient.
I authorize the release of all medical records to the referring and/or family physician and insurance company, if applicable.
I allow fax transmittal of my medical records, if necessary,
I acknowledge full financial responsibility for services rendered by de Ramon Plastic Surgery Institute, P.C., whether or not paid by insurance.
I agree to pay all reasonable attorney fees and collection cost in the event of default of payment of my charges.
I authorize and request that insurance payments be made directly to de Ramon Plastic Surgery Institute, P.C.
I understand that payment of charges occurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
I consent to the use of photography for pre and post-operative analysis, peer review, and educational purposes.
I have read and fully understand the above and sign with intent to be legally bound.

Date _____ Signature_____

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