

CHILDREN/MINOR  
PATIENT INTRODUCTION

(Please Print)

Salem Plastic Surgery

PLEASE COMPLETE AND RETURN TO THE RECEPTIONIST WITH YOUR INSURANCE CARD

Family Physician: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Address: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_  
First Middle Last

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_  
No. and Street or Route and Box No. City State Zip Code

Home Phone Number: ( ) \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Full Name

Mother's Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mother's Place of Employment: \_\_\_\_\_ Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Full Name

Father's Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Father's Place of Employment: \_\_\_\_\_ Phone: \_\_\_\_\_

Person Legally Responsible: \_\_\_\_\_  
(If minor-parent or guardian) Full Name

Relationship: \_\_\_\_\_ Their Phone Number: \_\_\_\_\_

Notify in Case of Emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

INSURANCE INFORMATION

Do you have Medicare?  Yes  No

Do you have Medicaid?  Yes  No

If yes give certificate number(s): \_\_\_\_\_

Insurance (1) \_\_\_\_\_  
Name of Insurance Company Address  
\_\_\_\_\_  
Policy or Certificate Number Group Number Coverage Code  
\_\_\_\_\_  
If Group, thru which Company? In whose name is this policy?

Insurance (2) \_\_\_\_\_  
Name of Insurance Company Address  
\_\_\_\_\_  
Policy or Certificate Number Group Number Coverage Code  
\_\_\_\_\_  
If Group, thru which Company? In whose name is this policy?

Workman's Comp/Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_