

PATIENT INTRODUCTION

(Please Print)

Salem Plastic Surgery, Inc.

PLEASE COMPLETE AND RETURN TO THE RECEPTIONIST WITH YOUR INSURANCE CARD

Family Physician:
Address:
Referring Physician:
Physician Address:

Today's Date:
Date of Injury:

How did you hear about our practice?

Mr.

Patient's Name: Mrs. Miss Age:
First / Middle / Maiden Last

Male
Female

Social Security Number: Date of Birth:

Marital Status: Single Married Separated Divorced Widowed D.L.#:

Patient's Address: No. and Street or Route and Box No. City State Zip Code

Home Phone Number: Business Phone Number:

Patient's Place of Employment: Job:

Business Address:

Name of Spouse: Full Name Age:

Social Security Number: Date of Birth:

Spouse Employed By:

Business Address: Phone:

Person Legally Responsible: Full Name
(if minor-parent or guardian)

Relationship: Their Phone Number:

Notify in Case of Emergency: Phone Number:

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, through 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, through which company?

In whose name is this policy?

Workman's Comp/Employer: Phone:

Address: