

Artisan Plastic Surgery, LLC
Current Patient Information

(PLEASE do not leave blank)

Reason for your visit (LIST PROCEDURE): _____

Who may we thank for your referral? _____

Patient: _____ Nickname: _____

Address: _____

Home Phone: _____ Work: _____ Cellular: _____

Email Address _____

Date of Birth: _____ Social Security #: _____

Employer/School: _____

Occupation: _____

If married, spouse's name: _____

Date Of Birth: _____ Social Security #: _____

Relative/Friend _____ Phone _____ Relationship _____

Responsible Party: _____ Relationship: _____

Address: _____

Home Phone: _____ Work: _____ Cellular: _____

INSURANCE INFORMATION:

Primary Policyholder: _____

Insured's Social Security: _____

Insured's Date of Birth: _____

Name of Insurance Company: _____

Policy # _____ Group # _____

Employer: _____ Occupation: _____

ANY MEDICAL HISTORY CHANGES SINCE LAST VISIT:

I authorize you to give me reasonable and proper medical care by today's standards. Due to the high cost of billing, we request payment for all office visits at the time of service. If you wish to file your own insurance claim, we will provide sufficient information in your receipt for you to do so. I accept responsibility as Guarantor for the above-named patient. I authorize release of any medical information necessary to process claims for service rendered. I assign, transfer, and sent over to Artisan Plastic Surgery, LLC all of my rights, title, and interest to my medical reimbursement benefits under insurance policy. I authorize payment of these benefits to Artisan Plastic Surgery, LLC. I accept responsibility for any balances unpaid by my insurance company.

Patient or Authorized Person:

Name (Printed): _____ Date: _____

Signature: _____ Date: _____