LAM PLASTIC SURGERY, LLC
PATIENT REGISTRATION - INSURANCE INFORMATION

Last Name _____ First Name _____ Initial_____

Address _____ City_____State_____

Telephone # _____ Cell # _____ Work # _____

Sex: M ___ F ___ E-mail Address _____

Date of Birth ____/____/____ SS# _____ Marital status _____

SpouseLast _____ First _____ DOB _____ SS# _____

In case of Emergency please contact **_____ phone # _____**

Whom may we thank for referring you to our practice? _____

The reason for your visit today? _____

EMPLOYMENT INFORMATION

Patient employer _____

Street Address _____

City _____ State _____ Zip _____

Phone # _____

EMPLOYMENT INFORMATION – SPOUSE

Spouse employer _____

Street Address _____

City _____ State _____ Zip_____

INSURANCE INFORMATION

Primary Insurance _____

Street Address _____

City _____ State _____ Zip _____

Phone # _____

ID# _____ Group # _____

Name of Policyholder_____

Secondary Insurance _____

Street Address _____

City _____ State _____ Zip _____

Phone # _____

ID# _____ Group # _____

Name of Policyholder_____

PRIMARY CARE PHYSICIAN

Physician's Name _____

Group Practice Name _____

Street Address _____

City _____ State _____ Zip _____

Phone # _____ Fax #_____

May we leave a detailed message on home or cell phone?

- ☐ **YES**
- ☐ **NO**

May we send information to your home address?

- ☐ **YES**
- ☐ **NO**

Are you interested in financing your cosmetic procedure?

- ☐ **YES**
- ☐ **NO**

I certify that the information given is accurate and correct. I am fully responsible for all charges not covered by any insurance company. I authorize payment of medical benefits directly to the treating physician and also authorize the release of any medical information necessary to process insurance claims. I further agree that this authorization will cover all medical services rendered until such authorization is revoked by me.

DATE _____

SIGNATURE _____

(Patient or Power of Attorney)