PATIENT INFORMATION

Date:_____

Name(last, first, MI):_____Sex: Male Female
Address:_____City:_____State_____Zip_____
Home Phone #: ( )_____Cell: ( )_____Work #: ( )_____
Date of Birth: _____ Age: _____ SS# _____Email: _____

What would you like us to call you? Do you have a nickname? _____
Where may we call you? HOME WORK CELL ANY
May we leave a message with a family member on a machine? YES NO
May we mail/email you information on services our office or our affiliates offer? YES NO
What would you like to achieve with Plastic Surgery?_____
What Procedure are you interested in? _____
What time frame are you considering? 1-3 months 6-12 months Just need information
Are you interested in financing? YES NO
Who may we thank for referring you? _____

MARITAL STATUS (please circle): SINGLE MARRIED DIVORCED SEPARATED WIDOWED

SPOUSE (or parent if minor):
Name:_____SS#:_____Date of Birth_____
Home Phone#: ( )_____ Work #: ( ) _____

YOUR EMPLOYMENT INFORMATION:
Occupation:_____ Employer:_____
Address:_____ Phone #: ( )_____

RESPONSIBLE PARTY'S NAME: _____ Phone # ( ) _____

PRIMARY INSURANCE:
Insurance Carrier: _____ Subscriber Name:_____
Address: _____Policy I.D.#:_____
City, State & Zip:_____ Group # _____
Phone #: ( ) _____

EMERGENCY INFORMATION:

Name: _____Relationship:_____
Address:_____City & State: _____
Zip: _____ Phone #: ( )_____

I hereby irrevocably assign and transfer all payment of benefits for the services rendered by Mark Mofid, M.D. to be made directly to him regardless of my insurance benefits, if any, and agree to allow a photocopy of my signature to be used to file insurance. I understand that each patient (or responsible party) is financially responsible for services rendered. In the instance of dispute with my insurance company regarding payment, I authorize Mark Mofid, MD to act on my behalf. While the business office is pleased to assist in the preparation and submission of insurance forms, the obligation for payment remains that of the responsible party. In the case of an accepted Worker's Compensation injury, it is understood that the patient is not financially responsible. I also authorize Mark Mofid, MD to render medical treatment.

_____ _____
Patient Signature Responsible Party's Signature

_____ _____
Date Date