Zollman Plastic Surgery
Patient Information
Please print and provide the following information completely

Last Name: _____First Name: _____MI: _____

Address: _____City: _____State: _____Zip: _____

Home Phone: _____E-mail Address: _____

SSN: _____ -_____ -_____ DOB: _____ Sex: M F Marital Status: S M D W
mm/dd/yy

Employer Name: _____ Work Phone#: _____

Address: _____ City: _____ State: _____ Zip:_____

Emergency Contact Name: _____ Phone: _____

Alternate Phone# :_____ Did you attend a Seminar? Yes No

Referral Information

How did you hear about us? (Please be as specific as possible.)

- ❑ **SBC Yellow Pages *or* Yellow Book (Please circle)**
- ❑ **Internet: Search Engine DocShop Directory LocateADoc.com (Please circle) Other: _____**
- ❑ **Radio Station: 92.3 93.1 94.7 95.5 99.5 103.3 (Please circle) Other: _____**
- ❑ **Word of Mouth: _____ Friend: _____ Doctor: _____**
- ❑ **Reach Magazine, ValPack or Other Magazine/Newspaper (Please circle) Other: _____**
- ❑ **Seminar Date and Location of Seminar: _____**

Insurance/Work Comp Information

Insurance Holder Name: _____ Policy No.: _____ Group No.: _____
Employer Name: _____ Phone No.: _____
W/C Insurance: _____Phone #: _____
Address: _____City: _____State: _____ Zip: _____
Contact Person: _____

I certify that the above information is correct to the best of my knowledge. I hereby authorize Zollman Plastic surgery to release my information regarding services rendered to me and allow a photo copy of my signature to be used to file insurance claims. I hereby authorize and direct my insurer to issue payment checks for the benefits due to me for services rendered by Zollman Plastic Surgery directly to Zollman Plastic Surgery. Regardless of my insurance I am financially responsible for the fees for services rendered. This includes, but is not limited to co-insurance, co-payments, deductible and non-covered service. I understand that should it become necessary to file suit to recover and uncollected charges I will be responsible for all court costs, reasonable attorney fees and interest due. I consent to have my photograph taken by an employee of Zollman Plastic Surgery and permit their use for medical records, medical record education and medical lectures.

_____ _____

Signature of Patient or Guardian **Date**