



Today's Date \_\_\_\_\_

**Patient Information --Please Print**

**Guarantor Information--Relationship to Pt.** \_\_\_\_\_

Name \_\_\_\_\_  
Last First M.I.  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
HOME WORK  
CELL ( ) \_\_\_\_\_  
E-mail address \_\_\_\_\_

Name \_\_\_\_\_  
Last First M.I.  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
HOME WORK  
CELL ( ) \_\_\_\_\_

Male Female (circle one) Marital Status \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Social Security Number \_\_\_\_\_

Male Female (circle one) Marital Status \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
Social Security Number \_\_\_\_\_

Referring Dr. \_\_\_\_\_ Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Referring Dr. \_\_\_\_\_ Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Primary Care Dr. \_\_\_\_\_ Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Primary Care Dr. \_\_\_\_\_ Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Name of nearest relative *not* living with you and whom we may contact in case of emergency:

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**\*Primary Insurance Carrier** \_\_\_\_\_ Subscriber \_\_\_\_\_

Copay \$ \_\_\_\_\_ Policy numbers \_\_\_\_\_

**\*Secondary Insurance Carrier** \_\_\_\_\_ Subscriber \_\_\_\_\_

Copay \$ \_\_\_\_\_ Policy numbers \_\_\_\_\_

Policy numbers \_\_\_\_\_

**\*Blue Cross** Group \_\_\_\_\_ Service Code \_\_\_\_\_ Contract \_\_\_\_\_

**\*Medicaid** (8 digit ID #) \_\_\_\_\_ **\*Medicare** \_\_\_\_\_

I understand according to the State of Michigan, Department of Health, Act 488 of 1988 that if a health care professional in this facility sustains a cutaneous, mucous membrane, or open wound exposure to blood or other body fluids from myself that an HIV and Hepatitis-B (HBV) blood test will be performed.

Signature \_\_\_\_\_ Date \_\_\_\_\_

I authorize payment of medical benefits directly to Grand Rapids Plastic Surgery, PC. I also request payment of government benefits either to myself or to the party who accepts assignment.

Signature \_\_\_\_\_ Date \_\_\_\_\_

I understand that I am financially responsible for any services or materials not covered by my insurance and for any yearly deductible or co-payment amounts. I agree to pay all services within 30 days unless a payment plan is negotiated in advance. I authorize the physician to release any information and/or photos required to process my claim, and any information deemed necessary by the doctor to be sent via fax transmission. This request shall remain in effect until revoked by me in writing.

Signature \_\_\_\_\_ Date \_\_\_\_\_