Date _____

Chart Number _____

PATIENT INFORMATION

*First*_____ *M.I.* _____ *Last*_____ *(Nick Name)*_____

*Date of Birth*_____ *Age* _____ *Marital Status*_____ *Gender* ☐Male ☐Female

*Address*_____ *City*_____ *State*_____ *ZIP*_____

*SS#*_____ *Email Address* _____

*Primary Phone*_____ ☐Home ☐Cell *Secondary Phone*_____ ☐Home ☐Cell

How would you like us to communicate with you? Choose all that apply:

Appointment Reminders ☐ Email ☐ Text ☐Phone (Home / Cell) *Please Circle One*

Scheduling or Medical Questions ☐ Email ☐ Text ☐Phone (Home / Cell) *Please Circle One*

Monthly Specials and Discounts ☐ Email ☐ Text

Employer _____ *Occupation* _____ *Phone*_____

*Whom may we contact in case of an emergency? Name*_____

*Relationship*_____ *Phone*_____

Referring Dr. _____ *Phone*_____

Primary Dr. _____ *Phone*_____

How did you hear about our office? _____

Name of person who referred you _____

INSURANCE & BILLING INFORMATION

*Primary Insurance*_____ Subscriber_____

Specialist Copay $_____ Group Number_____ Policy Number_____

*Secondary Insurance*_____ Subscriber_____

Specialist Copay $_____ Group Number _____ Policy Number_____

RESPONSIBLE PARTY'S INFORMATION (Must complete this section if patient is under the age of 18)

Name _____ *Relationship to Patient*_____

*Date of Birth*_____ *Marital Status*_____ *Gender* ☐Male ☐Female

*Address*_____ *City*_____ *State*_____ *ZIP*_____

*Primary Phone*_____ ☐Home ☐Cell *Secondary Phone*_____ ☐Home ☐Cell

Employer _____ *Occupation* _____ *Phone*_____

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. 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_____