Patient Information (Part 2 of 3)

Instructions: Please fill out this form to the best of your ability so we can better serve you.

If the question does not apply, write "N/A" or just skip it.

Note: *We apologize there are repeat questions; this is due to HIPAA compliance reasons and keeping medical forms separate for your privacy.*

Full Name

First Name | Middle Name | Last Name

Sex

- ❍ Male
- ❍ Female

Status

- ❍ Single
- ❍ Married

Social Security Number

Date of Birth

0 Month | **0** Day | **0** Year

Mailing Address

Street Address

Street Address Line 2

City | State / Province

Postal / Zip Code | **0** Country

Home Phone

Area Code | Phone Number

Cell Phone

Area Code | Phone Number

Work Phone

Area Code | Phone Number

Alternative Phone

_____ _____
Area Code Phone Number

Email

_____

How do you prefer to be contacted?

- ❍ Email
- ❍ Phone

Employer Name

_____

Emergency Contact

Full Name

_____ _____
First Name Last Name

Relationship

_____

Emergency Phone

_____ _____
Area Code Phone Number

Medical Contacts

Do you have a primary care physician?

- ❍ Yes
- ❍ No

Preferred Pharmacy

_____

Pharmacy Phone

_____ _____
Area Code Phone Number

How did you hear about us?

- ❍ Physician
- ❍ Friend/Relative
- ❍ Internet
- ❍ _____

Insurance Information - Primary

Primary Insurance Carrier _____

Policy Holder Name

_____ _____
First Name Last Name

Relationship to Patient _____

Policy Holder Employer _____

Occupation _____

Date of Birth

0 **0** **0**
Month Day Year

Group Number _____

Insurance ID Number _____

Policy Holder Social Security Number _____

Is the Card Holder Address different from the one above?

- ❍ Yes
- ❍ No

Do you have secondary insurance coverage?

- ❍ Yes
- ❍ No

Insurance Information - Secondary

Secondary Insurance Carrier _____

Policy Holder Name _____ _____
First Name Last Name

Relationship to Patient _____

Policy Holder Employer _____

Occupation _____

Date of Birth **0** **0** **0**
Month Day Year

Group Number _____

Insurance ID Number _____

Policy Holder Social Security Number _____

Is the Card Holder Address different from the one above?
- ❍ Yes
- ❍ No

Injury related?

Did your injury happen on the job?
- ❍ Yes
- ❍ No

of Benefits

❑ I, the undersigned, certify that I (or my dependant) have insurance coverage with the above stated company(s) and assign directly all benefits to Plastic Surgery of Houston, Dr. Jay Shenaq. I understand I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I also agree to the statement below.

❑ I hereby give my permission to have the appropriate photos taken for the purpose of completing my medical records.

In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as full charge, and the patient agrees to be responsible for any and all deductible, coinsurance, and non-covered services. I authorize the use of this signature on all insurance submissions.

Date

_____ _____ _____

Month Day Year

Submit