How were you referred to our office?_____

Patient Information

Patient Name:
(Last)_____(First)_____(MI)_____
Date of Birth: ___/___/_____Social Security:_____-___-_____ Drivers License #:_____State_____
Address: _____Apt:_____
City: _____State: _____ Zip:_____
Best contact phone number, circle one: Cell, Home, or Work
Cell:_____ Home: _____ Work:_____
E-mail: _____
Employer:_____Occupation_____
Address: _____
City: _____State: _____ Zip:_____

Insurance and Policy Holder Information

Primary Insurance Company: _____
Policy #_____ Group #_____
Insurance Company Address: _____
City_____ State_____ Zip code_____
Insurance Company Phone: _____Policy Holder Relationship_____
□ Check box if Policy Holder Information (below) is same as Patient Information
Policy Holder Information Name: (Last)_____(First)_____(MI)_____
Date of Birth: ___/___/_____Social Security:_____-___-_____DriversLicense#:_____State_____
Address: _____ Apt:_____
City: _____State: _____ Zip: _____
Best contact phone number for policy holder, circle one: Cell, Home, or Work
Cell:_____ Home: _____ Work: _____
Policy holder e-mail: _____
Policy holder employer: _____Occupation _____
Policy holder employer address: _____
City: _____State: _____ Zip: _____
Secondary Insurance Company: _____
Policy #_____ Group #_____
Insurance Company Address: _____
City_____ State_____ Zip code_____
Insurance Company Phone: _____Policy Holder/Relationship _____
□ Check box if Secondary Insurance Policy Holder Information (below) is same as Primary Insurance
Policy Holder Information: Name: (Last)_____(First)_____(MI)_____
Date of Birth: ___/___/_____Social Security:_____-___-_____ Drivers License #:_____State_____
Address: _____ Apt:_____
City: _____State: _____ Zip: _____
Best contact phone number for policy holder, circle one: Cell, Home, or Work
Cell:_____ Home: _____ Work: _____
Policy holder e-mail: _____
Policy holder employer: _____Occupation _____
Policy holder employer address: _____
City: _____State: _____ Zip: _____

12201 Renfert Way, Suite 100
Austin, TX 78758
P 512.763.4545 F 512.763.4546

1250 8th Ave, Suite 265
Fort Worth, TX 76104
P 682.200.8580 F 682.200.8581

10900 Hefner Pointe Dr, Suite 505
Oklahoma City, OK 73120
P 405.246.0391 F 405.246.0392

Release of Medical Information:

Who may we share your medical information with?
1. _____ Relationship:_____
2. _____ Relationship:_____
3. _____ Relationship:_____

Are you currently receiving any disability benefits through social security? Y/N
Have you applied to receive benefits through social security disability? Y/N

Pharmacy Information:

Name: _____ City: _____
Phone: _____

Emergency Contact Information:

Name of Person to Contact in an Emergency: _____
Relationship to Patient: _____
Phone number: _____ Alternate number:_____

Consent for treatment:

I voluntarily give my permission to the health care provider(s), associates, and such assistant(s) as they may deem necessary to provide medical services to me. I understand by signing this form, I am authorizing them to treat me for as long as I seek care from the physician and associates, or until I withdraw my consent in writing. This includes contacting the designated person indicated on this form in case of emergency, and/or the release of pertinent information to local authorities if my provider(s), associates, and such assistant(s) determine a welfare check is necessary.

Statement of Financial Responsibility/Assignment of Benefits:

I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by Plastic Surgery Associates. I assign and authorize payments to Plastic Surgery Associates. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or State or Federal law.

Patient or Guardian Signature: _____Date:_____

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Photo Consent

Patient _____

I authorize Plastic Surgery Associates, and office staff ("Authorized Parties") to take pre-, intra-, and post-operative photos during the course of my evaluation and treatment.

I understand that the photos may be stored on electronic or paper medical records. As able, patient identifying features are excluded.

I approve the photos to be used for the following purposes:

- Clinical documentation
- Testing and credentialing with the American Board of Plastics Surgeons
- Educational activities directed at patients and other physicians
- Presentations to medical and non-medical organizations
- Presentation at local, regional, national, or international meetings
- Publication in medical journals
- Marketing purposes such as brochures, educational pamphlets, and website

I understand my clinical care will not be affected by my choice to authorize or not authorize use of the photographs for the above stated purpose.

I hereby release and hold harmless the Authorized Parties of and from any and all claims, demands, damagers or causes of action in connection with the use of the photographs I have hereby authorized.

Patient or Guardian Signature: _____Date:_____

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