GLASSMAN PLASTIC SURGERY, PLLC

LAWRENCE S. GLASSMAN, M.D.

PATIENT NAME:_____

FIRST NAME MIDDLE NAME LAST NAME

STREET ADDRESS:_____

CITY:_____STATE:_____ZIP CODE_____SEX: M__F__

E-MAIL:_____

HOME PHONE:_____CELL PHONE_____

DATE OF BIRTH_____SS#_____MARITAL STATUS: S___M___D___W_____
REFERRING PHYSICIAN/FRIEND_____RACE:_____
EMPLOYER:_____WORK PHONE:_____
EMPLOYER ADDRESS_____
SPOUSE'S EMPLOYER:_____SPOUSE WORK PHONE_____
SPOUSE'S EMPLOYERS ADDRESS:_____
EMERGENCY CONTACT NAME_____PHONE#_____
PRIMARY INSURANCE:_____POLICY#_____
PRIMARY CARE PHYSICIAN_____GROUP#_____
ADDRESS:_____TELEPHONE#:_____
RELATIONSHIP TO INSURED:_____
POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT):_____
SS# OF POLICY HOLDER (IF DIFFERENT FROM PATIENT):_____
DATE OF BIRTH OF POLICY HOLDER (IF DIFFERENT FROM PATIENT):_____
SECONDARY INSURANCE:_____POLICY#_____
ADDRESS:_____TELEPHONE#_____
RELATIONSHIP TO INSURED:_____
POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT):_____
DATE OF BIRTH OF POLICY HOLDER (IF DIFFERENT FROMPATIENT):_____
TERTIARY INSURANCE:_____POLICY#_____
RELATIONSHIP TO INSURED:_____DOB:_____
POLICY HOLDER NAME (IF DIFFERENT FROM PATIENT):_____
DATE OF BIRTH OF POLICY HOLDER (IF DIFFERENT FROM PATIENT):_____

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO GLASSMAN PLASTIC SURGERY, PLLC, ATTORNEY FEES AND COSTS OF COLLECTION IN THE EVENT OF DEFAULT UP TO 33% ADDITIONAL CHARGE FOR COLLECTION FEE. INSURANCE IS NOT ACCEPTED AS PAYMENT IN FULL.

SIGNED:_____**DATE:**_____

I AUTHORIZE ANY HOLDER OF MEDICAL OR ANY OTHER INFORMATION ABOUT ME TO RELEASE MY INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE AND FINANCING ADMINISTRATIONS, ITS INTERMEDIARIES, CARRIERS INSURANCE COMPANIES, BILLING AND COLLECTION AGENTS OF THESE PHYSICIANS.

SIGNED:_____**DATE:**_____