PLASTIC SURGICAL ASSOCIATES

Plastic and Reconstructive Surgeons
HEALTH QUESTIONNAIRE

PLEASE PRINT CLEARLY Social Security Number: _____ Date: _____

Name _____ Phone: ( ) _____
Last First Middle

Address _____
Street and Number City State Zip Code

Date of Birth _____ Age _____ Sex _____ Your Occupation _____ Spouse s Occupation _____

Marital Status: S ___ M ___ D ___ W ___ Sep ___ Race _____ Religion _____ Maiden Name: _____

Spouse or closest relative _____ Phone: ( ) _____

Address: _____

Patient s Employer _____ Phone: ( ) _____

Address _____

IN EMERGENCY NOTIFY: _____

_____

Responsible Party - Financially _____

Address: _____

REASON FOR VISIT _____

If Injury: Date: _____ Place _____

Where Treated _____ Physician _____

REFERRED BY: _____

If lawyer is involved _____
Name and Address

INSURANCE INFORMATION

Some HMO and PPO Insurance plans require prior authorization on certain exams for payment consideration. If your exam required authorization and it has not been obtained by you, or your referring physician, prior to service, you may be financially responsible for payment.

1) I understand I may be financially responsible for payment if my insurance has lapsed.

2) I understand I may be financially responsible for payment if the exam being performed required authorization and authorization has not been obtained.

3) I understand I am responsible for any co-payments relating to my policy.

PRIMARY INSURANCE GROUP #	SECONDARY INSURANCE GROUP #
ADDRESS INS. ID #	ADDRESS INS. ID #
CITY STATE ZIP	CITY STATE ZIP
SUBSCRIBER NAME SS #	SUBSCRIBER NAME SS #
EMPLOYER RELATIONSHIP TO PATIENT	EMPLOYER RELATIONSHIP TO PATIENT
DATE OF BIRTH SEX	DATE OF BIRTH SEX

I CERTIFY THAT THE ABOVE IS TRUE AND CORRECT. I ALSO KNOW THAT IT IS A CRIME TO FILL OUT THIS FORM WITH INCORRECT FACTS OR TO LEAVE OUT INFORMATION WHICH I KNOW IS IMPORTANT.

Signature of patient or responsible party _____ Date _____

(OVER)