

Patient Information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name

_____ First Middle Last

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? No Yes E-mail _____

Contact Restrictions: _____

Age _____ Birthdate _____ SS# _____ Gender Female Male

Marital Status Single Married to: _____ Other: _____

Patient's Employer

_____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? Yes No

Address _____
Street & Suite # City State Zip

How did you hear about Dr. Flint?

(Mark all that apply)

Internet Website: pattiflintmd.com Looking Your Best American Society of Plastic Surgeons Natrelle
 Phoenix Magazine Yellow Pages

Friend/Relative: _____ Doctor: _____ Other: _____

If you were referred by a specific person, may we thank them? Yes No

Emergency Contact

_____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Primary Health Insurance Company

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? No Yes Copay? No Yes, \$ _____

Insured: Name _____ DOB _____ Employer _____

Secondary Health Insurance Company

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? No Yes Copay? No Yes, \$ _____

Insured: Name _____ DOB _____ Employer _____

Assignment and Release: I hereby assing all major medical and/or surgical insurance benefits to which I am entitled, including Medicare, private insurance or any other health plan, to Patti A. Flint, M.D. I understand that I am financially responsible for all charges, whether or not paid by said insurance, unless assignee has an executed agreement with my insurance plan or provider, indicating otherwise. I understnd if such an agreement exists, I am responsible for payment of any deductibles and/or co-payments required under the terms of my insurance plan. Should collection procedures become necessary, I agree to pay all costs associated with the collection of this debt, including but not limited to attorney's fees and court cost. I hearby authorize pre and post-operative photographs to be taken of me for my medical records and for insurance purposes. I hereby authorize assignee to release any and all information obtained in the course of my examination and treatment to secure payment of insurance benefits. A photocopy of this assignment and release shall be considered as valid as it's orgininal.

Signature

Date
