PATTI FLINT, M.D., FACS, P.C. (480) 945-3300

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 insuance 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 orginінal.

Signature ______________________________ **Date** ____________