WRIGHT PLASTIC SURGERY, P.C.

PATIENT INFORMATION QUESTIONNAIRE

(All Information Confidential)

PATIENT

Name ______________________________
Last First MI

Address ______________________________

City, State ______________________________

Zip Code ______________________________

Home Phone ______________________________

Business Phone ______________________________

Employer ______________________________

Occupation ______________________________

Birthdate ______________ Age ______________

Social Security # ______________________________

Sex ________ Marital Status ______________

RESPONSIBLE PARTY (if different) or Spouse Info.

Resp. Party ______________________________
or Spouse Last First MI

Address ______________________________

City, State ______________________________

Zip Code ______________________________

Home Phone ______________________________

Business Phone ______________________________

Employer ______________________________

Occupation ______________________________

Birthdate ______________ Age ______________

Social Security # ______________________________

Family Physician ______________________________

In Emergency Contact (Name & Phone Number) ______________________________

INSURANCE COMPANY INFORMATION

PRIMARY INSURANCE

Insurance Co. ______________________________

ID# ______________________________

Group # ______________________________

SECONDARY INSURANCE

____

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FOR AUTO ACCIDENT CLAIMS/WORKER'S COMPENSATION CLAIMS (circle one)

Insurance Co. ______________________________ Date of Accident/Injury ______________

Claim # ______________________________ Policy # ______________________________

Contact Person/Adjuster: ______________________________ Telephone # ______________

AUTHORIZATION FOR RELEASE OF INFORMATION

- I HEREBY AUTHORIZE ASSIGNMENT AND PAYMENT DIRECTLY TO PHYSICIAN OF MAJOR MEDICAL BENEFITS DUE ME.
- I HEREBY AGREE TO PAY ANY AND ALL CHARGES THAT EXCEED OR THAT ARE NOT COVERED BY INSURANCE.
- I AUTHORIZE THE PHYSICIANS OF WRIGHT PLASTIC SURGERY, P.C. TO OBTAIN ANY MEDICAL INFORMATION THEY MAY NEED TO PARTICIPATE IN MY MEDICAL CARE.
- I HEREBY AUTHORIZE YOU TO TAKE APPROPRIATE PHOTOGRAPHS FOR PURPOSES OF COMPLETING MY RECORDS, AS ILLUSTRATIONS FOR LECTURES TO MEDICAL OR NON-MEDICAL AUDIENCES OR FOR PUBLICATIONS IN MEDICAL BOOKS OR JOURNALS. (YOU MAY DELETE ANY PHRASE YOU OBJECT TO.)
- I AUTHORIZE THE PHYSICIANS OF WRIGHT PLASTIC SURGERY, P.C. TO RELEASE INFORMATION, INCLUDING FAXED FINRORMATION, TO ANY PERSON PARTICIPATING IN MY MEDICAL CARE. I RELEASE WRIGHT PLASTIC SURGERY, P.C. FROM ANY LIABILITY IN THE EVENT THAT UNAUTHORIZED INDIVIDUALS RECEIVED MEDICAL INFORMATION NOT INTENDED FOR THEIR USE THROUGH FAXED TRANSMITTAL. I AUTHORIZE THE PHYSICIANS OF WRIGHT PLASTIC SURGERY, P.C. TO RELEASE INFORMATION TO MY INSURANCE COMPANY OR WORKER'S COMPENSATION CARRIER ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT. I AUTHORIZE MEDICARE TO FURNISH TO THE PHYSICIANS OF WRIGHT PLASTIC SURGERY, P.C. ANY INFORMATION REGARDING MY MEDICAL CLAIMS UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT.
- I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF WRIGHT PLASTIC SURGERY, P.C.'S PRIVACY NOTICE. Yes ☐ No ☐

Signature ______________________________ Date ______________ Relationship to Patient ______________