NORTHERN JERSEY PLASTIC SURGERY CENTER, LLC

PATIENT INFORMATION SHEET

Name: First _____Middle _____ Last _____

Address _____

City _____ State _____ Zip Code _____

Home Phone (_____)_____ Work Phone (_____)_____

Cell Phone (_____)_____

Social Security Number _____-_____-_____Date of Birth _____/_____/_____ Age: _____ □ Male □ Female

E-mail address _____ Marital Status □ S □ M □ D □ W

Emergency Contact _____ Emergency Phone _____ Relationship_____

Your Primary care physician? _____ Phone (_____)_____
(If you go to a group, please specify the name of the physician you see most often.)

Pharmacy Name/Address _____ Phone _____

Employment Status: □ Employed □ Student □ Retired

Employer Name/Address _____City & State _____

INSURANCE INFORMATION

Name of Primary Insurance Company _____Policy #_____ Group #_____

Name of Secondary Insurance Co. _____ Policy #_____ Group #_____

POLICY HOLDER INFORMATION (if other than Patient)

Name: _____ Relationship to Patient _____ Date of Birth _____/_____/_____

Social Security Number _____-_____-_____ Address (if different than patient) _____

Employer Name, Address & Phone _____(_____)_____

HOW DID YOU HEAR ABOUT OUR PRACTICE?

____ A Physician Name _____ Phone _____

_____Family/Friend Name _____

_____Advertisement Which publication/program _____

Authorization to Release Information: I authorize Northern Jersey Plastic Surgery Center, LLC to release any information necessary, acquired in the course of my treatment, to process insurance claims. ***Initial here _____

Authorization to Pay Benefits Directly: I authorize my insurance company to pay Northern Jersey Plastic Surgery Center, LLC directly for medical service rendered. I understand that I will be responsible for non-covered charges, balances after insurance company benefits, deductibles and copayments. Also, I understand that in the event that this account needs to be placed with an attorney or a collection agency because of an unpaid balance remaining on my account, I hereby agree and promise to pay interest of 2% per month of the outstanding balance (to be calculated starting from my last date of service). In addition, I also agree and promise to pay a collection fee of $100.00 or 40% of the total balance, whichever is greater, upon placement with an attorney or collection agency due to an unpaid balance remaining on my account. ***Initial here _____

*** _____ _____
Signature Date