Palm Beach Facial Plastic Surgery
4280 Professional Center Drive, Suite 310
Palm Beach Gardens, FL 33410
(561) 659-9766
www.PalmBeachFacialPlastic.com

Patient Information Form

Patient Name: ______________________ Today's Date: ____________

Address: ______________________ City: ____________ State: ______ Zip: ______

Home Phone: ____________ Cell Phone: ____________ Carrier: ______________________

DOB: ____________ Age: ____________ Gender: ____________

Preferred Language: ____________ Race: ____________ Ethnicity: ____________

Social Security Number: ____________ Email Address: ______________________

Employer Name: ______________________ Address: ______________________

Occupation ______________________ Work Phone: ____________

Pharmacy Name (where you want prescriptions sent to): ______________________

Pharmacy Address: ______________________ Pharmacy Phone: ____________

Who is your primary care physician? ______________________

How did you hear about us?

- ☐ PalmBeachFacialPlastic.com
- ☐ Web Search Engine
- ☐ Office Promotion: ____________
- ☐ Other: ______________________
- ☐ Patient Referral: ____________
- ☐ Friend: ____________
- ☐ Dr. Referral: ____________
- ☐ Insurance Referral: ____________

What is the nature of your visit? ______________________

Emergency Contact

Name: ______________________ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: ____________

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

Primary Insurance

Insured Name: ______________________ Insured Date of Birth: ____________

Name: ______________________ Policy #: ____________ Group ID: ____________

Address: ______________________ City: ____________ State: ______ Zip: ______

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Secondary Insurance

Name: ______________________ Policy #: ______________ Group ID: ______________

Assignment and Release

I, ______________________________, have insurance coverage and assign all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

______________________________________ ______________

Signature of Insured / Guardian Date