Desert Plastic Surgery

Cosmetic and Reconstructive Plastic Surgery

John M. Pierce, M.D.

Patient Name_____ **Age**_____ **Date of Birth**_____
Last First M.I.

How Would You Like To Be Addressed: _____

Street Address_____ **City**_____ **State**_____ **Zip**_____

Home Phone (___)_____ **Cell Phone** (___)_____ **E-mail**_____

How would you like to be contacted?: _____

Gender: ☐ **Male** ☐ **Female** **Marital Status:** ☐ **Married** ☐ **Single** ☐ **Widowed** ☐ **Divorced** ☐ **Separated**

Occupation:_____ **Employer:**_____ **Social Security #:**_____

Employer Address:_____ **Employer Phone:** (___)_____

Emergency Contact Person:_____ **Relationship:** _____ **Phone:** (___)_____

Patient Referred by:_____ **Primary Physician:** _____

Reason For This Visit: _____

Are There Any Other Procedures/Services You Are Interested In?_____

Have You Seen Any Other Plastic Surgeons For This Problem: ☐ **Yes** ☐ **No** **If yes, list names:** _____

How Did You Hear About Our Practice: _____

Would You Like To Be Added To Our Newsletter Mailing List (need E-mail address): ☐ **Yes** ☐ **No**

Insurance Plan Name: _____ **Address:** _____

Policy or ID Number: _____ **Group #:** _____ **Effective Date:** _____

Insured Name (if different than patient): _____

Insured Social Security Number:_____ **Insured Date of Birth:**_____

Secondary Insurance: _____ **Policy #:** _____

Person Financially Responsible: ☐ **Patient** ☐ **Spouse** ☐ **Parent** ☐ **Other** _____

Authorization for Assignment & Release (All Patients/Guarantors must sign and date this section)

I authorize my insurance benefits to be paid the practice/doctor. I authorize my medical information to be released as required to justify medical necessity on billing documents. I understand and agree to be responsible for any elective or non-covered services that may be provided. I understand that I am financially liable for payment for services rendered and that I am responsible for providing all pertaining insurance information to expedite insurance reimbursement. I agree to pay my required co-pay at the time of service, and agree that if I do not possess current insurance coverage, that I will pay in full for services rendered at the time of service. I request that payment of authorized Medicare benefits be made on my behalf to Desert Plastic Surgery for any services provided to me if indicated.

Patient/Guarantor Signature _____ **Date** _____