PALO VERDE PLASTIC SURGERY

JOHN M. ROWLEY, M.D.

Certified American Board of Plastic Surgery

PATIENT INFORMATION (please print)

Patient's Last Name: _____ **First**: _____ **Middle**: _____ **Gender**: _____

Date of Birth: _____ Age: _____ Social Security No: _____ Marital Status: S M W D SEP

Address (street, city, state, zip):_____

Best Daytime Phone #: _____ cell/home/work (circle) Permission to leave a voice message? Y / N Permission to text message? Y / N

Alternate Phone #: _____ cell/home/work (circle) Permission to leave a voice message? Y / N Permission to text message? Y / N

Email Address: _____ Permission to email? Y / N

Employment Status: ❑EMPLOYED ❑ SELF EMPLOYED ❑ NOT EMPLOYED ❑ RETIRED ❑ STUDENT Occupation: _____

Name & Address of **Employer**: _____ Employer's Phone #: _____

Emergency Contact: _____ Relationship: _____ Phone #:_____

Address (street, city, state, zip):_____

Primary Care Doctor: _____ Phone #: _____

Preferred Pharmacy Name & Location (city & crossroads):: _____

How did you hear about us? : ❑Insurance Co. ❑Dr.:_____ ❑Website: _____ ❑Family/Friend: _____

Responsible Party (or parent, if minor) Last Name: _____ First: _____ Middle: _____

Date of Birth: _____ Age: _____ Social Security No: _____ Marital Status: S M W D SEP

Best Daytime Phone #: _____ cell/home/work (circle) Permission to leave a voice message? Y / N Permission to text message? Y / N

Alternate Phone #: _____ cell/home/work (circle) Permission to leave a voice message? Y / N Permission to text message? Y / N

Email Address: _____ Permission to email? Y / N

Employment Status: ❑EMPLOYED ❑ SELF EMPLOYED ❑ NOT EMPLOYED ❑ RETIRED ❑ STUDENT Occupation: _____

Name & Address of Employer: _____ Employer's Phone #: _____

INSURANCE INFORMATION (please print)

Primary Insurance Company: _____ **Policy Holder's Full Name**: _____

Relationship to Patient: _____ Date of Birth: _____ Social Security No: _____

Policy Holder's Address: _____

Policy Holder's Phone #: _____ cell/home/work (circle) Permission to leave a voice message? Y / N Permission to text message? Y / N

Policy Holder's Name & Address of Employer: _____ Employer's Phone #: _____

Secondary Insurance Company: _____ Policy Holder's Full Name: _____

Relationship to Patient: _____ Date of Birth: _____ Social Security No: _____

Policy Holder's Address: _____

Policy Holder's Phone #: _____ cell/home/work (circle) Permission to leave a voice message? Y / N Permission to text message? Y / N

Policy Holder's Name & Address of Employer: _____ Employer's Phone #: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

GIVING US PERMISSION TO LEAVE A VOICEMAIL, TEXT MESSAGE, OR TO EMAIL, INCLUDES WHAT MAY BE PROTECTED HEALTH INFORMATION (ie: test results, appointment reminders, etc). UNLESS STATED OTHERWISE, WE WILL POTENTIALLY MAIL INFORMATION TO THE ADDRESS YOU PROVIDE. I authorize payments of medical benefits to the provider for services rendered, or to be rendered in the future, without obtaining my signature on each claim submitted, and I will be bound by the signature as though I personally signed the claim. I also authorize the release of medical information necessary. I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES, should this account be referred to a collection agency, I will also be responsible for any collection and/or legal fees. I have read and understand.

_____ _____ _____

PATIENT OR RESPONSIBLE PARTY SIGNATURE PRINT NAME DATE