

PATIENT INFORMATION FORM | LEONARD PLASTIC SURGERY

leonardplasticsurgery@gmail.com

WELCOME TO OUR OFFICE

In order to serve you, we need the following information.
All information is strictly confidential.

Today's Date _____

Referred by _____

GENERAL INFORMATION

Patient's Name _____ Birthdate _____ Age _____

Social Security # _____ Sex _____ Marital Status _____ Spouse's Name _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

Employer _____ Address _____

Occupation _____

In case of emergency call _____ Phone _____

If patient is a minor: _____

Responsible party _____ Social Security # _____

Address (if different from above) _____

Employer _____ Address _____

Occupation _____

Home Phone _____ Work Phone _____ Cell Phone _____

Relationship of responsible party to patient _____

INSURANCE

Primary Insurance Company _____

Insured Name _____

Insured's Birthdate _____

Secondary Insurance Company _____

Insured Name _____

Insured's Birthdate _____

ACCIDENT

Is this an on-the-job, automobile, or household accident? _____

Date of injury _____ If unable to work, date last worked _____

Where did injury occur? _____

How did injury occur? _____

Previous doctors seen for this injury _____

Name of Insured _____ Insurance Company _____

Policy or Claim # _____ Claim rep. _____

If applicable, attorney's name _____ Phone _____

Assignment & release: I hereby assign payment directly to Dann K. Leonard, MD and authorize release of any medical information necessary to secure payment of benefits, consent to medical photography and authorize release for medically related purposes. I am responsible for any charges not paid by my insurance. I am aware payment is due at the time of service unless prior arrangements were made with patient accounts. If it becomes necessary to enforce collections of any amount owed on this or subsequent visits the undersigned agrees to pay all costs and expenses, including attorney's fees. All accounts assigned to a collection agency will be charged an additional \$100.00 collection fee.

Signature _____

Guardian Signature _____

Date _____