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 _____