

**PATIENT INFORMATION FORM**  
**WELCOME TO MARCHANT PLASTIC SURGERY**

In order to serve you properly, please complete the following information. All information is strictly confidential.

**\*\*\*GENERAL INFORMATION\*\*\***

Patient's Name \_\_\_\_\_  
(Last) (First) (Middle)

Birth Date \_\_\_\_\_ Social Security # \_\_\_\_\_

Street Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_  
Area code Area code

Cell Phone ( ) \_\_\_\_\_ E-mail \_\_\_\_\_  
Area code

NAME OF SPOUSE (OR PARENT if minor) \_\_\_\_\_

**\*\*\*REFERRAL INFORMATION\*\*\***

Reason for visit \_\_\_\_\_

How were you referred? (Circle) Friend Yellow Pages Website \_\_\_\_\_ Other \_\_\_\_\_

Name of other family members seen by our practice \_\_\_\_\_

Referring physician \_\_\_\_\_ Primary care physician \_\_\_\_\_

**\*\*\*INSURANCE\*\*\***

Primary Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Subscriber Name (if other than patient) \_\_\_\_\_ Subscriber Birth Date \_\_\_\_\_

**\*\*\*RECEIPT OF NOTICE OF PRIVACY PRACTICES\*\*\***

I have received a copy of the Notice of Privacy Practices. The medical practice has given me an opportunity to ask questions about this notice and all my questions have been answered.

**X** \_\_\_\_\_ **Date** \_\_\_\_\_  
(Patient, or Parent if Minor)

**\*\*\*ASSIGNMENT OF BENEFITS\*\*\***

I authorize payment of any insurance benefits to Dr. Marchant for professional services rendered.

**X** \_\_\_\_\_ **Date** \_\_\_\_\_  
(Patient, or Parent if Minor)

**\*\*\*FINANCIAL RESPONSIBILITY\*\*\***

I understand that I am financially responsible for all charges for all services to me, including the balance remaining after payment of possible insurance benefits.

**X** \_\_\_\_\_ **Date** \_\_\_\_\_  
(Patient, or Parent if Minor)

**\*\*\*RELEASE OF MEDICAL INFORMATION\*\*\***

I authorize the release of any medical information necessary to process this medical claim.

**X** \_\_\_\_\_ **Date** \_\_\_\_\_  
(Patient, or Parent if Minor)