



Summit Plastic Surgery & Dermatology

(Please fill out in ink only.)

Privacy Restrictions or other patient requests:

Last Name: _____ First Name: _____ MI: _____

Sex: _____ Date of Birth: _____ SS#: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Marital Status: Single Married Widowed Divorced

Home Phone: _____ Cell: _____ Work Phone: _____

*****Please circle the telephone number where we can best reach you or leave a message*****

Spouse/Responsible Party Information:

Last Name: _____ First Name: _____ MI: _____

SS#: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Referring Physician: _____ Family Physician: _____

Pharmacy: _____ Telephone: _____

Assignment and Release: I hereby assign my insurance benefits to be paid directly to Summit Plastic Surgery and Dermatology. I am financially responsible for ALL NON-COVERED services. I also authorize the physician to release any information required to process my claim to my employer or insurance company.

(Signature of patient or parent if minor)

Date:

I give permission for my medical information or test results to be released to the following people:

1. _____ Relationship _____

2. _____ Relationship _____

3. _____ Relationship _____

Can we leave a message on your answering machine? YES NO