



New Patient Information Form

Patient Information M _____ F _____

Name (First, Middle, Last): _____ Title: _____

Date of Birth (MM/DD/YYYY) _____ Social Security No. _____

Street Address _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ Occupation: _____

Phone (Cell): _____ Phone (Home): _____

Phone (Work): _____ Preferred Method of Contact: _____

Preferred Time to Contact: _____ OK to leave message (yes/no): _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Number: _____

Person responsible for payment if patient under the age of 18:

Name (First, Middle, Last): _____ Title: _____

Date of Birth (MM/DD/YYYY) _____ Gender M _____ F _____

Street Address _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ Occupation: _____

Phone (Cell): _____ Phone (Home): _____

Person responsible SS#: _____

Referral Sources

Primary Care Physician: _____ Referring Physician: _____

How did you hear about Criswell & Criswell Plastic Surgery (please circle all that apply):

A friend (their name, optional): _____

Word of mouth Primary care physician Specialist physician

Drive-by/walk-by Yellow Pages YellowPages.com

Magazine:

Charlotte Magazine Ballantyne Magazine Charlotte Woman

New Beauty Magazine Southpark Magazine Redbook

CriswellandCriswell.com Webpage

Please add my name to the Criswell & Criswell Plastic Surgery eNews group for occasional updates on plastic surgery events and special offers (please circle): **Yes / not at this time**

Insurance Information: Primary Coverage

Insurance Company Name: _____ Effective Date: _____
ID Number: _____ Group Number: _____
Subscriber Name (Person holding the insurance): _____
Subscriber Date of Birth (if different than above): _____
Subscriber SS # : _____ Phone Number: _____
Insurance Claim Address (if different than above): _____
City: _____ State: _____ Zip Code: _____
Patient Relationship to Subscriber: _____

Insurance Information: Secondary Coverage

Insurance Company Name: _____ Effective Date: _____
ID Number: _____ Group Number: _____
Subscriber Name (Person holding the insurance): _____
Subscriber Date of Birth (if different than above): _____
Subscriber SS # : _____ Phone Number: _____
Insurance Claim Address (if different than above): _____
City: _____ State: _____ Zip Code: _____
Patient Relationship to Subscriber: _____

Thank you for choosing our practice! We are committed to the success of your treatment and care. Please understand that payment of your bill is part of this treatment and care. If you need any assistance with our financial policies or procedures, please ask to speak with our Billing Specialist or our Practice Manager.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

Authorization for Treatment: I hereby authorize such examinations, treatments, medications, and minor surgical procedures as may be prescribed by the Criswell & Criswell Plastic Surgery physician in charge of my care.

Authorization to Release Information: I authorize the physicians of Criswell & Criswell Plastic Surgery to release my information required in the course of my treatment for insurance Purposes. I authorize my insurance benefits be paid directly to Criswell & Criswell Plastic Surgery.

I acknowledge the opportunity to review Criswell & Criswell Plastic Surgery’s Notice of Privacy Practices.

Date

Signature

Printed Name