Mission Plastic Surgery

Allen M. Doezie M.D., F. A. C. S.
Patient Information Form

LEGAL First Name:_____MI_____Last Name:_____
Date of Birth: _____/_____/_____ Social Security#: XXX - XX - _____ Male or Female
Address: _____
City: _____ State:_____ ZipCode_____
Primary Phone: _____ Secondary Phone: _____
Marital Status: _____ Spouse's Name _____
E-mail: _____Subscribe to E-mail List: Yes No
Primary Care Physician: _____ Phone:_____
Pharmacy Name: _____
Pharmacy Location (street, city, cross street etc) _____
How did you hear about us? _____ May we thank them? Yes No
Emergency Contact: _____Phone: _____

Insurance Information
Self Pay/no insurance (Please Circle)
Parent, Spouse or responsible Party: (if different from patient)
Name: _____
Phone: _____Relationship to Patient: _____
Social Security: _____-_____-_____Employer/Occupation: _____
CellPhone:_____HomePhone:_____

Primary Insurance Coverage:
Insurance Co. Name: _____Provider Phone: _____
Name of Policy Holder: _____
D.O.B: _____
Policy ID#:_____Group#_____
Type Of Coverage: PPO_____ HMO_____ POS_____ Worker's Comp _____

Secondary Insurance Coverage:
Insurance Co. Name: _____Provider Phone: _____
Name of Policy Holder: _____
D.O.B: _____Policy ID#: _____
Group#: _____
Type Of Coverage: PPO_____ HMO_____ POS_____ Worker's Comp _____

Release of Information & Assignment of benefits: I authorize the release of medical information to my primary care physician or referring physician, labs, hospitals and consultants if needed and as necessary to process insurance claims, insurance applications, disability forms and prescriptions. I also authorize payment of medical benefits to the physician. By signing this form I promise too payi if insurance denies all or part of the claim.