

CARMEL COSMETIC AND PLASTIC SURGEONS

ELIZABETH GRASEE, M.D. DEBRA BERGMAN, M.D.

NAME _____ DATE: _____
LAST FIRST MI SEX: _____

ADDRESS _____
STREET CITY STATE ZIP

HOME PHONE _____ DATE OF BIRTH _____ SS# _____
CELL PHONE _____ E-MAIL _____
 MARRIED SINGLE SEPARATED DIVORCED WIDOWED NAME OF SPOUSE _____

HOW WERE YOU REFERRED TO US? HOW DID YOU BECOME AWARE OF US? (CHECK ALL THAT APPLY)
 PHYSICIAN NAME _____ FRIEND NAME _____ WEBSITE _____
 YELLOW PAGES OTHER _____

REASON FOR SEEING PHYSICIAN _____

PATIENT OCCUPATION _____

EMPLOYER'S NAME _____

EMPLOYER'S ADDRESS _____
STREET CITY ST ZIP

EMPLOYER'S PHONE _____ EXT _____

IN CASE OF EMERGENCY, PLEASE LIST NAME, PHONE NUMBER, AND RELATIONSHIP OF PERSON(S) TO CONTACT:

NAME _____ RELATIONSHIP _____ PHONE _____

NAME _____ RELATIONSHIP _____ PHONE _____

FAMILY PHYSICIAN (PC) _____ PHONE _____

ADDRESS _____
STREET CITY ST ZIP

WITH YOUR PERMISSION, WE WOULD LIKE TO NOTIFY YOUR FAMILY PHYSICIAN OF YOUR VISIT: YES NO

INSURANCE INFORMATION: IN ORDER TO ASSIST YOU IN THE SOMETIMES DIFFICULT AND TIME CONSUMING TASK OF COMPLETING MEDICAL INSURANCE FORMS, WE NEED THE FOLLOWING COMPLETED IN ITS ENTIRETY. IN ADDITION TO THIS FORM, PLEASE HAVE YOUR INSURANCE CARD OUT FOR THE RECEPTIONIST TO COPY. THANK YOU.

PRIMARY INSURANCE: (IF MORE THAN ONE INSURANCE, COMPLETE SECONDARY INSURANCE INFORMATION)
INSURANCE COMPANY _____ POLICY HOLDER'S DATE OF BIRTH _____
INSURANCE COMPANY ADDRESS _____
POLICY HOLDER _____ SOC SEC# _____ RELATIONSHIP TO PT _____
POLICY NUMBER _____ GROUP# _____ EMPLOYER _____ PHONE _____

SECONDARY INSURANCE
INSURANCE COMPANY _____ POLICY HOLDER'S DATE OF BIRTH _____
INSURANCE COMPANY ADDRESS _____
POLICY HOLDER _____ SOC SEC# _____ RELATION TO PT _____
POLICY NUMBER _____ GROUP # _____ EMPLOYER _____ PHONE _____

PLEASE SIGN AUTHORIZATION STATEMENT ON BACK

PLEASE SIGN BELOW:

I acknowledge I am financially responsible for any services rendered by Dr. Grasee/Dr. Bergman.

I authorize Carmel Cosmetic & Plastic Surgeon to use pre and post operative photographs taken of me in connection with medical or cosmetic services I receive from them for educational and medical practice purposes. I understand that Carmel Cosmetic & Plastic Surgeons will not identify me by name when using such photographs.

SIGNATURE (if child, responsible party)_____

DATE_____

PLEASE SIGN BELOW IF YOU WANT OUR OFFICE TO FILE WITH YOUR INSURANCE COMPANY

MEDICAL INSURANCE RELEASE

I authorize the release of medical information including photographs necessary to process any claim for services provided by Dr. Grasee / Dr. Bergman. I further authorize the release of medical benefits to Carmel Cosmetic & Plastic Surgeons. A copy of this authorization may be used in place of the original. I understand the physician's charges may exceed my insurance carrier's allowable payment, and if this should occur, I realize I will be responsible for that portion.

SIGNATURE (if child, responsible party)_____

DATE_____

MEDICARE PATIENTS

MEDICARE NOW REQUIRES US TO HAVE EACH OF OUR MEDICARE PATIENTS SIGN A ONE-TIME PAYMENT AUTHORIZATION. THANK YOU FOR YOUR COOPERATION.

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE MEDIGAP BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO CARMEL COSMETIC AND PLASTIC SURGEONS FOR ANY SERVICES FURNISHED TO ME BY THAT PRACTICE. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFIT PAYMENT FOR RELATED SERVICES.

PLEASE SIGN_____

DATE_____

