PALO VERDE PLASTIC SURGERY

JOHN M. ROWLEY, M.D.

Certified American Board of Plastic Surgery

PATIENT INFORMATION (please print)

Patient's Last Name:_____ First:_____ Middle:_____ Gender:_____

Date of Birth:_____ Age:_____ Social Security No:_____ Marital Status: S M W D SEP

Address (street, city, state, zip):_____

Best Daytime Phone#:_____ cell/home/work (circle) Permission to leave a voice message? Y / N Permission to text message? V / N

Alternate Phone#:_____ cell/home/work (circle) Permission to leave a voice message? V / N Permission to text message? V / N

Email Address:_____ Permission to email? V / N

Employment Status: ☐EMPLOYED ☐SELF EMPLOYED ☐NOT EMPLOYED ☐RETIRED ☐STUDENT Occupation: _____

Name& Address of Employer:_____ Employer's Phone#:_____

Emergency Contact:_____ Relationship:_____ Phone#:_____

Address (street, city, state, zip)::_____

Primary Care Doctor:_____ Phone#: _____

Preferred Pharmacy Name & Location (city& crossroads) _____

How did you hear about us?: ☐Insurance Co. ☐Dr.: ☐Website: ☐Family/Friend:

Responsible Party (or parent, If minor) Last Name:_____ First:_____ MIddle:_____

Date of Birth:_____ Age: _____ Social Security No:_____ Marital Status: S M W D SEP

Best Daytime Phone#:_____ cell/home/work {circle) Permission to leave a voice message? V / N Permission to text message? Y / N

Alternate Phone#:_____ cell/home/work (circle) Permission to leave a voice message? V / N Permission to text message? V / N

Email Address:_____ Permission to email? V / N

Employment Status: ☐EMPLOYED ☐SELF EMPLOYED ☐NOT EMPLOYED ☐RETIRED ☐STUDENT Occupation: _____

Name& Address of Employer:_____ Employer's Phone#:_____

INSURANCE INFORMATION (please print)

Primary Insurance Company:_____ Polley Holder's Full Name: _____

Relationship to Patient:_____ Date of Birth:_____ Social Security No:_____

Polley Holder's Address:_____

Policy Holder's Phone#:_____ cell/home/work (circle) Permission to leave a voice message? Y / N Permission to text message? V / N

Polley Holder's Name& Address of Employer:_____ Employer's Phone#:_____

Secondary Insurance Company:_____ Policy Holder's Full Name:_____

Relationship to Patient:_____ Date of Birth:_____ Social Security No:_____

Policy Holder's Address:_____

Policy Holder's Phone#:_____ cell/home/work (circle) Permission to leave a voice message? V / N Permission to text message? V / N

Policy Holder's Name& Address of Employer:_____ Employer's Phone#:_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

GIVING US PERMISSION TO LEAVE A VOICEMAIL, TEXT MESSAGE, OR TO EMAIL, INCLUDES WHAT MAY BE PROTECTED HEALTH INFORMATION (Ie: test results, appointment reminders, etc). UNLESS STATED OTHERWISE, WE WillPOTENTIALLY MAIL INFORMATION TO THE ADDRESS YOU PROVIDE. I authorize payments of medical bene- fits to the provider for services rendered, or to be rendered In the future, without obtaining my signature on each claim submitted, and I will be bound by the signature as thought personally signed the claim. I also authorize the release of medical information necessary, I UNDERSTAND I AM RESPONSIBLE FOR ALL CHARGES, should this account be referred to a collection agency, I will also be responsible for any collection and/or legal fees. I have read and understand.

PATIENT OR RESPONSIBLE PARTY SIGNATURE

PRINT NAME

DATE