

WELCOME TO OUR PRACTICE!



Please take a moment to complete this form so we can better assist you with your health care needs.

EAST LAKE
PLASTIC SURGERY CENTER

PATIENT INFORMATION

Date: _____ Account # _____

Last Name _____ First Name: _____ MI: _____ SS #: _____

Sex: M F Age _____ Date of Birth _____ Marital Status: S M D W SEP

Parents' Names if Patient is a Minor: Mother: _____ Father: _____

Spouse or Partner's Name: _____

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

Phone # home: () _____ cell: () _____ E-Mail: _____

Occupation _____ Employer Name: _____ work#: () _____

If Student: Full-Time Part-Time Name of School: _____

Notify in Case of Emergency: _____ Relation: _____ Phone #: () _____

Primary Care Doctor: _____ Phone #: () _____

How did you here about us? CHECK ALL THAT APPLY ER Internet Yellow Pages Yellow Pages Local newspaper Other _____

Doctor _____ Name _____ Patient _____ Name (Optional) _____ Friend _____ Name (Optional) _____

CARRIER INFORMATION

Primary Insurance: _____

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

Carrier Phone #: _____ Policy #: _____ Group #: _____

Name of Policy Holder if other than Patient: _____ Date of Birth: _____ SS#: _____

Relationship to Patient: _____

Secondary Insurance: _____

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

Carrier Phone #: _____ Policy #: _____ Group #: _____

Name of Policy Holder if other than Patient: _____ Date of Birth: _____ SS#: _____

Relationship to Patient: _____

PERMISSION FOR TREATMENT

I hereby voluntarily consent to and authorize medical care/diagnostic treatment and /or minor surgical treatment by **ISIDOROS MORAITIS, MD** deemed advisable and necessary in the diagnosis and treatment of my condition. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office. I authorize the use and disclosure of any of my past/current medical records for treatment and healthcare operations.

Signed: _____ Print Name: _____ Date: _____

AUTHORIZATION AND ASSIGNMENT

I hereby assign all medical/diagnostic/surgical benefits payable for the services rendered, to include major medical benefits to which I am entitled, including Medicare, Private Insurance and other health plans to **ISIDOROS MORAITIS, MD, PA.** I hereby authorize said assignee to release to CMS/Insurance Carriers and it agents all information needed to determine these benefits or benefits related to services. I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree, regardless of my insurance status, that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that Medicare and/or other Insurance Carriers do not cover all office services/ procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to the said assignee for services.

Signed: _____ Print Name: _____ Date: _____

Office Witness: _____ Print Name: _____ Date: _____