DAVIS & PYLE
PLASTIC SURGERY

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AT DAVIS & PYLE
PLASTIC SURGERY

PATIENT INFORMATION **CHART #** _____

Name: _____ Date Of Birth: _____ Age: _____
Last First Middle

Address: _____
Street Apt # City State Zip

Home Phone: _____ Optional Soc.Sec. # _____

Work Phone: _____ Cell Phone: _____

Male ❑ Female ❑ Marital Status: Single ❑ Married ❑ Divorced ❑ Other _____

Permission To Leave Messages: Yes ❑ No ❑ Occupation: _____

Email: _____ ❑ Send Appointment Reminders, Updates & Specials Via Email

Referred By: _____ Primary Medical Doctor: _____

Emergency Contact: _____ Relationship To Patient: _____

Cell Phone: _____ Work Phone: _____ ❑ OK To Discuss Medical Information

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Davis & Pyle Plastic Surgery

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____ acknowledge that I have received a copy of Davis & Pyle Plastic Surgery's Notice of Privacy Practices. This Notice descibes how Davis & Pyle Plastic Surgery may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____

(Signature of Patient, or Personal Representative) ***(Date)***

_____

(Relationship to Patient)

THE PARENT REQUESTING TREATMENT FOR A CHILD IS RESPONSIBLE FOR ALL FEES FOR SERVICES RENDERED. I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE ABOVE PHYSICIANS AND /OR SURGICAL FACILITY, REALIZING THAT I AM RESPONSIBLE TO PAY NON-COVERED SERVICES AND I HEREBY RELEASE PERTINENT MEDICAL INFORMATION TO MY INSURANCE CARRIERS.

_____ _____

Date Signature of Patient, Parent or Responsible Party

*Davis & Pyle Plastic Surgery is a Division of Aesthetic & Reconstructive Plastic Surgery, PLLC