

PACIFIC CENTER FOR PLASTIC SURGERY

□ LARRY S. NICHTER, M.D., F.A.C.S.

□ JED H. HOROWITZ, M.D., F.A.C.S.

PATIENT INFORMATION (PLEASE PRINT AND FILL OUT COMPLETELY)

FIRST NAME _____ M.I. _____ LAST NAME _____

GUARDIAN NAME (IF MINOR) _____ RELATIONSHIP _____

DATE OF BIRTH _____ AGE _____ SOCIAL SECURITY # _____ SEX: MALE/FEMALE

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ FAX _____

PAGER _____ CELL _____ E-MAIL _____

EMERGENCY CONTACT _____ RELATIONSHIP TO PATIENT _____

PHONE _____

EMPLOYER NAME _____ OCCUPATION _____

ADDRESS _____ PHONE _____

INSURANCE INFORMATION (PLEASE PRINT AND FILL OUT COMPLETELY)

PRIMARY INSURANCE _____ NAME OF INSURED _____

INSURANCE PHONE _____ ID # _____ GROUP# _____

SECONDARY INSURANCE _____ NAME OF INSURED _____

INSURANCE PHONE _____ ID# _____ GROUP# _____

REFERRING PERSON OR PHYSICIAN (PLEASE PRINT AND FILL OUT COMPLETELY)

NAME _____ PHONE _____ FAX _____

ADDRESS _____

PRIMARY CARE PHYSICIAN: _____ PHONE _____ FAX _____

ADDRESS _____

PHOTOGRAPHY CONSENT

I authorize the physician or his assistant to take photographs. The term "photograph" includes Polaroids, 35mm slides, standard photographs, videotape, etc. These photographs are the doctor's property and will be a permanent part of the record. These may be used for teaching, lecture, educational conference, publication.

SIGNATURE _____ DATE _____

AUTHORIZATION FOR PAYMENT AND RELEASE OF MEDICAL RECORDS

I authorize release of medical records and payment to the physician and allow a photocopy of my signature to be used to file insurance. I understand that my insurance may not cover all fees and services provided and I will be responsible for the unpaid balance.

SIGNATURE _____ DATE _____