

Patient Information

Gary D. Hall, M.D.

Name _____
(Last) (First) (Middle)

Date of Birth ____/____/____ Social Security Number ____-____-____ Marital Status S M W D

Address _____
(Number) (City) (State) (Zip)

Age ____ Sex M F Phone No. (Residence) (____) _____
(Cell No.) (____) _____

Employer _____ (Business) (____) _____
Occupation _____ Email Address _____

Reason for Consultation _____ Date of Injury ____/____/____

Where did accident Occur? Work _____ Auto _____ Home _____ Other _____
How did you hear about our office? Yellow Pages Physician Friend Mailing Internet Other _____

Referring Physician _____ Primary Physician _____
Phone _____ Phone _____

Spouse, Parent or Emergency Contact
Name _____ Relationship _____

Address _____ Phone No. (____) _____
Employer _____ Phone No. (____) _____

Insurance

Please allow Receptionist to copy your cards

Copay: _____

Primary Insurance Company _____
Policy Number _____ Group Number _____

Policyholder _____ Relationship _____

Policyholder's Social Security No ____-____-____ Policyholders Date of Birth ____/____/____

Policyholder's Employer _____

Secondary Insurance Company _____
Policy Number _____ Group Number _____

Policyholder _____ Relationship _____

Policyholder's Social Security No ____-____-____ Policyholders Date of Birth ____/____/____

Policyholder's Employer _____

Payment Responsibility

I acknowledge that I have been provided with Advanced Cosmetic Surgery Privacy Practices.

Patient Signature: _____ or Legal Guardian: _____

Patient unwilling/unable to sign acknowledgment _____ Date: _____

Insurance Authorization and Assignment

I hereby authorize Advanced Cosmetic Surgery to furnish information to insurance carriers concerning my illness and treatments and hereby assign to Advanced Cosmetic Surgery all payments for medical services rendered to myself or my dependents.

I understand that I am responsible for any amounts not covered by insurance.

Date: _____ Signature: _____

Medicare Lifetime Consent

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Advanced Cosmetic Surgery for any services rendered by them. I authorize any holder of medical information about me to release Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Date: _____ Signature: _____