Patient Information

Date _____ Birth Date _____ Please list all current medical conditions:

Name _____ 1.

Sex ___ Marital Status S__ M__W__D___P___ 2.

Email Address _____ 3.

Street _____ 4.

City/State/Zip _____ Please list all current medications:

Home Phone _____

Cell Phone _____ 1. 4.

Employer/Occupation _____ 2. 5.

Phone _____ 3. 6.

Personal Physician _____

Referring Physician _____ Allergies _____

Other Referral _____ Have you ever had Hepatitis? Yes___No ___

Person Responsible for Bill _____ Relationship _____

Address _____ Phone _____

INSURANCE INFORMATION

Company ID Number Group Number

1._____

2. _____

My Relationship to Insured: Self _____ Spouse _____ Child _____ Other _____

If the insurance is in someone else's name, please fill in:

Name of Insured Person _____

Address _____

Phone _____

I authorize the release of medical information necessary to process claims for medical benefits. I authorize payment of medical benefits to Edward H. Stolar, MD, Todd E. Perkins, MD, and Saurabh Singh, MD, for services provided. I agree to p H. Stolar, MD, Todd E. Perkins, MD, and Saurabh Singh, MD, all co-payments, coinsurance, deductibles and any non-cover stipulated under my insurance plan. Non-covered services include cosmetic procedures not medically necessary and any service that has not been authorized by my insurance company. **I understand that there will be a $50 charge for missed office visits and $100 charge for missed surgical appointments if notice is not given a full business day before the appointment.**

Signed _____ Date _____

Revised 08/2013