

# IRVINE PLASTIC SURGERY CENTER

## PATIENT INFORMATION

NAME: \_\_\_\_\_  
(LAST) (FIRST) (MIDDLE INITIAL)

ADDRESS: \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

BIRTHDATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_ SEX: F \_\_\_ M \_\_\_ DRIVER'S LICENSE# \_\_\_\_\_

TELEPHONE #: \_\_\_\_\_ REFERRED BY: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ MARITAL STATUS: S \_\_\_ M \_\_\_ D \_\_\_ W \_\_\_

EMPLOYER NAME: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE #: \_\_\_\_\_

## RESPONSIBLE PARTY (IF DIFFERENT THAN ABOVE)

NAME: \_\_\_\_\_ TELEPHONE#: \_\_\_\_\_  
(LAST) (FIRST)

ADDRESS: \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

RELATIONSHIP TO PATIENT: \_\_\_\_\_ DRIVER'S LICENSE #: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ MARITAL STATUS: S \_\_\_ M \_\_\_ D \_\_\_ W \_\_\_

EMPLOYER NAME: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

WORK ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE #: \_\_\_\_\_

## PRIMARY INSURANCE COMPANY

Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Group/Policy #: \_\_\_\_\_

SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Name of Subscriber: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

## SECONDARY INSURANCE COMPANY

Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Group/Policy #: \_\_\_\_\_

SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Name of Subscriber: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**ASSIGNMENT:** I ALSO ASSIGN AND REQUEST PAYMENT OF MEDICAL BENEFITS TO IRVINE PLASTIC SURGERY CENTER FOR MEDICAL SERVICES. I ALSO UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY INSURANCE.

**RELEASE OF INFORMATION:** I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_