JANIGA MDs
PLASTIC SURGERY | DERMATOLOGY

How did you hear about us? (Please circle):

Internet Yellow Pages Friend_____

Mailer Doctor Referral TV Other_____

Name_____

Soc Sec #_____

Age_____ **Sex**_____

Birth date_____

Address_____

City_____

State_____ Zip_____

Phone_____

Cell Phone_____

May we contact you by text: Y or N?

Email_____

May we contact you by email: Y or N?

Employer_____

Work Phone_____

In case of emergency please notify: circle one

Spouse/partner/friend/guardian/parent

Name_____

Phone_____

Referring Doctor_____

Address_____

City_____ **State**_____

Primary Insurance_____

Name of Primary Insured_____

DOB of Primary Insured_____

Primary Insured SS#_____

Primary Insured Employer _____

ID or Member #_____

Group # _____

Secondary Insurance_____

Name of Insured_____

ID# or Member #_____

Group# _____

I hereby authorize the release of information regarding my illness and treatment to my insurance carriers and billing company. I also authorize payment of medical benefits to the provider of services rendered. I understand that I am responsible for any amount not covered by my insurance. In addition, insurance carriers may make payments for procedures and subsequently request repayment from the physician when they consider the original payment inappropriate. I am aware that I am responsible for payment under such a circumstance. I declare the statements above are true to the best of my information, knowledge and belief.

Patient Signature or Parent if Minor:

_____

Date_____