INTAKE FORM

PLEASE ANSWER ALL QUESTIONS

NAME _____ AGE_____ BIRTHDATE_____
last first middle initial

PATIENT'S SOCIAL SECURITY #_____ PATIENT'S DRIVER LICENSE#_____

HOME ADDRESS_____
street apt number

_____
city state zip code

HOME (_____)_____CELL (_____)_____ WORK (_____)_____

BEST CONTACT NUMBER (Please circle one) ☐ HOME ☐ CELL ☐ WORK

E-MAIL_____

EMPLOYER_____ OCCUPATION_____

EMPLOYER ADDRESS _____
street city state zip code

NAME OF SPOUSE / PARENT / RESPONSIBLE PARTY (if other than patient)_____

HOME ADDRESS_____
street city state zip code

HOME (_____)_____CELL (_____)_____ WORK (_____)_____

EMPLOYER_____ OCCUPATION_____

EMPLOYER ADDRESS _____
street city state zip code

NEAREST RELATIVE NOT LIVING WITH YOU_____

RELATIONSHIP _____ PHONE(_____)_____

PRIMARY PHYSICIAN_____

ADDRESS / PHONE_____

REASON FOR INITIAL CONSULTATION (LIST ALL)_____

INTAKE FORM

INSURANCE REIMBURSEMENT

NAME OF PATIENT'S PRIMARY INSURANCE CO _____

POLICY # _____ GROUP# _____

NAME OF SUBSCRIBER (if other than patient) _____

RELATIONSHIP TO PATIENT (Please circle one) SPOUSE / PARENT / CHILD

SUBSCRIBER SOCIAL SECURITY # _____ SUBSCRIBERS BIRTHDATE _____

NAME OF SECONDARY INSURANCE CO _____

POLICY # _____ GROUP# _____

NAME OF SUBSCRIBER (if other than patient) _____

RELATIONSHIP TO PATIENT (Please circle one) SPOUSE / PARENT / CHILD

SUBSCRIBER SOCIAL SECURITY # _____ SUBSCRIBERS BIRTHDATE _____

STATEMENT OF FINANCIAL RESPONSIBILITY

The service(s) you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. If applicable and indicated, we will verify your coverage and bill your insurance carrier on your behalf, as a courtesy to you. However, you are ultimately responsible for payment of your bill in full.

PLEASE READ CAREFULLY: YOUR INSURANCE CARRIER MIGHT NOT FULLY REIMBURSE YOU FOR HOSPITAL ADMISSION OR SURGICAL PROCEDURES!

Most group insurance policies have just recently been amended to include preadmission certification requirements for hospital admissions and/or second surgical opinion requirements for selected surgical procedures. I understand that this is my responsibility to fulfill any preadmission or second opinion requirements contained in my insurance policy. I realize that failure to do so may result in a significant reduction in my insurance benefits. I, the undersigned, have read the above policy regarding my financial responsibility to Divino Plastic Surgery, for providing services to me or the patient mentioned below. I certify that the information, to the best of my knowledge, true and accurate. I hereby assign Divino Plastic Surgery all payments to which I am entitled for medical and/or surgical expenses related to the services reported for my illness or injury. I understand that I am financially responsible to said provider for charges not covered by this assignment of benefits. A copy of this assignment is as valid as the original.

_____

PATIENT (PRINT NAME) DATE

_____

PATIENT SIGNATURE

_____

GUARANTOR (PRINT NAME) DATE

_____

GUARANTOR SIGNATURE

SELF PAY

I do not have health insurance and will be responsible for services rendered here at Divino Plastic Surgery. I agree to pay the full and entire amount for services rendered.

_____

PATIENT/GUARANTOR SIGNATURE DATE