

Account Number _____

Patient Information Sheet

Patient's Name _____ Marital Status S M W D SEP
 (Print) Last Name First Name Middle Initial E-mail _____
 May we contact you by e-mail? Yes No

Male/Female Age _____ Date of Birth _____ SS # _____
 Address _____ P.O. Box _____
 City _____ State _____ Zip Code _____
 Home Phone _____ Work Phone _____
 Employer _____ Cell Phone _____
 Name (Relationship) Emergency Contact _____ Phone # _____

Information may be shared with the following people:

 _____ Signature _____

Insurance Information

Primary Insurance Company _____
 Subscriber's Name _____ SS # _____
 Sex _____ Date of Birth _____ Relationship to Patient _____
 ID Number _____ Group/Plan _____
 Employer _____

Secondary Insurance Company _____
 Subscriber's Name _____ SS # _____
 Sex _____ Date of Birth _____ Relationship to Patient _____
 ID Number _____ Group/Plan _____
 Employer _____

Financial Agreement

The physician's fees for cosmetic surgery are payable in full two weeks in advance of surgery. If you have any insurance that requires pre-certification, prior approval, or second surgical opinion, it is your responsibility to inform this office so proper certification, approval or second surgical opinions may be obtained. Failure to do so may result in loss of benefits to you. This office offers assistance in completing insurance or compensation benefits forms for surgery. Dr. Bastug will be happy to discuss any questions you may have regarding their fees and services.

Authorization of Assignment of Benefits

I request payment of authorized benefits be made to Dr. Bastug on my behalf for any services furnished me or my covered dependents. I authorize any holder of medical or other information about me to release to my insurance company and its agent(s) any information needed to determine these benefits or benefits for related services.

I have read this statement. I understand that I am responsible for all charges for services rendered by Dr. Deniz F. Bastug regardless of insurance or compensation benefits received.

Patient's Signature _____ Date _____