

PATIENT INFORMATION

DATE: _____

PATIENT NAME: _____

DATE OF BIRTH: _____ AGE: _____

PERMANENT ADDRESS: _____

CITY _____ STATE _____ ZIP _____

HOME PHONE: _____ CELL: _____ WORK _____

SOCIAL SECURITY # _____ E-MAIL: _____

SEX: MALE FEMALE **MARITAL STATUS:** SINGLE MARRIED DIVORCED WIDOWED

RESPONSIBLE PARTY OR SPOUSE: _____

PRIMARY INSURANCE: _____

SECONDARY INSURANCE: _____

PATIENT OCCUPATION: _____

EMPLOYER: _____

REFERRED BY: _____

PHYSICIAN'S RELEASE AND ASSIGNMENT:

I hereby authorize payment directly to (Yoav Barnavon, M.D., P.A. or James D. Stern, M.D., P.A.) of benefits due to me from my insurance company and otherwise payable to me. I further authorize the release of any medical information required by my insurance carrier(s). a copy of this authorization may be used in lieu of the original. Regardless of my insurance benefits, if any, I understand I am financially responsible for the fees for services rendered.

I hereby agree to pay any and all cost involved in the collection of charges for services rendered.

Signature of responsible party

Witness

I hereby consent and authorize (Yoav Barnavon, M.D., P.A. or James D. Stern, M.D., P.A.) to take photographs of myself as it relates to my medical problem. I further authorize the use of these photographs as well as medical records for teaching, research, publications in medical journal, or to fulfill the requirement set out by the American Board of Plastic Surgery, Inc. (Do not feel obligated to sign this release, as it will in no way interfere with your treatment on your surgery.)

Signature of responsible party

Witness