

**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

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RESPONSIBLE PARTY OR SPOUSE: \_\_\_\_\_

PRIMARY INSURANCE: \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_

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PATIENT OCCUPATION: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

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REFERRED BY: \_\_\_\_\_

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**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