Hamilton Facial Plastic Surgery

Patient Information

Name (Last, First, MI)	Age	Date of Birth	SSN	Today's Date

Home Address	City	St	Zip	Home Phone #

Employer	City	St	Zip	Work Phone #

Sex	Marital Status	Spouse's Name	Children's Name (Age)	Cell Phone #
M F	Single Married Divorced Separated			

E-Mail Address	Interested in Receiving Newsletter (3-4 per year) Via E-Mail?	Interested in Receiving Practice/Aesthetic Updates & Specials Via E-Mail?
	Y N	Y N

Person to Contact in Case of Emergency			Primary Care Physician	
Name	Relationship	Phone #	Name	Phone #

How were you referred? (Check all that apply)

Name

- ☐ Patient _____
- ☐ Physician _____
- ☐ Friend _____
- ☐ Yellow Pages
- ☐ Newspaper
- ☐ T.V.
- ☐ Radio
- ☐ Seminar

Magazine:

- ☐ Indianapolis Women
- ☐ Indianapolis Monthly
- ☐ Indiana Business Journal (IBJ)

☐ Other _____

Address

Do you want copies of reports done here forwarded to your doctor? Y N

What Surgical Procedure are You Interested in?

- ☐ Rhinoplasty (nose)
- ☐ Chemical Peel
- ☐ Hair Transplant
- ☐ Repair of torn earlobe
- ☐ Chin implant
- ☐ Dermabrasion
- ☐ Skin Care
- ☐ Forehead Lift
- ☐ Eye lid Lift
- ☐ Scar Revision
- ☐ Removal of cysts, moles, etc.
- ☐ Face or neck lift
- ☐ Protruding Ears
- ☐ Correction _____
- ☐ Other _____

Primary Insurance	Group #	ID #

Member Name	Relationship	Member's SSN	Member's DOB	Member's Employer

I recognize and accept full financial responsibility for all professional services rendered, regardless of the amounts covered by any applicable insurance coverage. In the event Hamilton Facial Plastic Surgery is required to collect your account after default, you will be responsible for all attorney fees and cost of collection. If insurance is to be filed, I authorize release of medical information including photographs necessary to process any claim for service provided by Hamilton Facial Plastic Surgery. I further authorize any insurance company to pay benefits directly to Hamilton Facial Plastic Surgery.

Date _____ Signature of Patient / Responsible Party _____ Relationship to patient _____