HARRIS PLASTIC SURGERY

PATIENT'S NAME _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ **Cell Phone** _____ **Best Contact #** _____

E-MAIL _____ **Any restrictions in contacting you?** ☐ No ☐ Yes **Explain:** _____

Age _____ **Birthdate** _____ **SS#** _____ ☐ Female ☐ Male

Marital Status ☐ Single ☐ Married to: _____ ☐ Other _____

REASON FOR VISIT Consultation for: (*please be specific*)_____

REFERRED BY _____ Relationship to Patient _____ Phone _____

PRIMARY CARE PHYSICIAN _____
Name Address Telephone Number

PATIENT'S EMPLOYER _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ☐ Yes ☐ No

Address _____
Street & Suite # City State Zip

EMERGENCY CONTACT

Name _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____
Street & Apt # City State Zip

***INSURANCE POLICY/OUT OF NETWORK DISCLOSURE*:** **DR. STEPHEN HARRIS DOES NOT PARTICIPATE WITH ANY INSURANCE *EXCEPT* MEDICARE, NO FAULT AND WORKERS COMP. DR. HARRIS WILL BILL FOR SERVICES TO YOUR "OUT OF NETWORK BENEFITS", *AND* THE PATIENT WILL BE RESPONSIBLE AND BILLED FOR THEIR DEDUCTIBLE AND CO-INSURANCE. BY SIGNING BELOW, I ACKNOWLEDGE RECEIPT OF THIS INFORMATION, UNDERSTAND THIS DISCLOSURE AND AGREE TO PAY MY DEDUCTIBLE AND CO-INSURANCE.**

PRIMARY HEALTH INSURANCE COMPANY **INSURANCE CO. NAME** _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ☐ No ☐ Yes Copay? ☐ No ☐ Yes, $ _____

Insured Name: _____ **DOB** _____ **SS#** _____ Employer _____

SECONDARY HEALTH INSURANCE COMPANY **INSURANCE CO. NAME** _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ☐ No ☐ Yes Copay? ☐ No ☐ Yes, $ _____

Insured Name: _____ **DOB** _____ **SS#** _____ Employer _____

By signing below, I verify that all the above information is correct, and I understand the OUT OF NETWORK DISCLOSURE LAW regarding my insurance.

SIGNATURE: _____ **Date** _____