

PATIENT INFORMATION

NAME _____

FULL ADDRESS W/ZIP CODE _____

TELEPHONE(_____) _____ CELL (_____) _____ EMAIL _____

BIRTH DATE _____ MALE () FEMALE () SOCIAL SECURITY # _____

SINGLE () MARRIED () WIDOWED () DIVORCED () MINOR (under 18) ()

PATIENT'S EMPLOYER _____ BUSINESS PHONE (_____) _____

BUSINESS ADDRESS _____

SPOUSES NAME _____ SPOUSES DOB _____

ADDRESS (If different) _____

PARENTS NAME (If minor) _____

INSURANCE INFORMATION

WHO IS THE PRIMARY INSURANCE HOLDER? () Spouse () Mother () Father () Self

INSURED'S NAME _____ INSURED'S DOB _____

PRIMARY INSURANCE CO. _____

INSURED' SOCIAL SECURITY # _____

MAILING ADDRESS _____

POLICY CONTRACT # _____ GROUP NAME/NUMBER _____

SECONDARY INSURANCE CO. _____

MAILING ADDRESS _____

POLICY CONTRACT # _____ GROUP NAME/NUMBER _____

WHO IS THE PRIMARY POLICY HOLDER (If not Self)? _____

RELATIONSHIP TO YOU _____ THEIR DOB _____

ASSIGNMENT OF BENIFITS: For assigned claims only, I hearby assign all medical and/or surgical benefits, to include major medical benefits to which i am entitled' including Medicare and any other government sponsored programs. private insurance and any other health plans to Lawrence G. Kass, M.D. This will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that i am financially responsible for all charges not paid by said insurance. I hearby authorize said assignee to release all necessary information to secure this payment.

SIGNED _____ DATE _____

Do I take care of any other members of your family? Please list their names if I do. _____

THANK YOU. I WILL BE WITH YOU AS SOON AS POSSIBLE.

**The Center For
Cosmetic Facial &
Eye Plastic Surgery**

Lawrence G. Kass, M.D., F.A.A.C.S.

*Fellow, American Academy of Cosmetic Surgery
Fellow, American Society of Ophthalmic Plastic & Reconstructive Surgery*