Date_____

Pt ID #_____

ADVANCED PLASTIC SURGERY CENTER
Richard. D. Redman, M.D.
PATIENT INFORMATION SHEET- PLEASE PRINT

Name_____
last first middle initial

Social Security #_____Birthdate_____

Age_____Sex_____Race_____Marital Status_____

Address_____
street/number city state ZIP code

Home Phone #_____Work Phone #_____

Cell Phone #_____ Please circle your preferred daytime phone #:
Home Work Cell

E-mail Address_____

Employer_____Occupation_____

Person to notify in case of emergency_____Relation_____

Home #_____Work #_____Cell #_____

Responsible Party (if other than patient) _____
last first middle initial

Address_____
street/number city state ZIP code

Home #_____Work #_____Cell #_____

Family Physician_____

A referral is the greatest compliment. Please let us know who referred you to Dr. Redman.

Referral Source_____

AUTHORIZATION FOR DISCLOSURE OF INFORMATION
Kindly bring your insurance card with you at the time of your initial visit.

I hereby authorize Advanced Plastic Surgery Center to furnish information to my insurance carrier(s) concerning my illness and treatments.

Signature_____ Date_____

I hereby authorize direct payment to Advanced Plastic Surgery Center for medical services rendered to my self or my dependents. I understand that I am responsible for any amount that insurance does not cover such as co-pays, deductibles, etc.

Signature_____ Date_____

Ptinfo