

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 # _____

E-mail Address _____

Employer _____ Occupation _____

Person to notify in case of emergency _____

Relation _____ Home # _____ Work # _____

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

Address _____
street/number city state ZIP code

Home # _____ Work # _____

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