PERIMETER PLASTIC SURGERY, LLC

1267 HWY 54 W SUITE 5300 FAYETTEVILLE, GA 30214 980 JOHNSON FERRY RD SUITE 760 ATLANTA, GA 30342

PLEASE USE BLACK INK TO COMPLETE FORMS

_____

LAST NAME **FIRST NAME** **MIDDLE INITIAL**

_____

STREET ADDRESS

_____

CITY **STATE** **ZIP CODE**

_____-_____-_____ _____-_____-_____ _____-_____-_____ _____

HOME PHONE **CELL PHONE** **WORK PHONE** **EXT.**

_____

PRIMARY CARE PHYSICIAN NAME AND ADDRESS

_____

REFERRING PHYSICIAN NAME AND ADDRESS (IF NOT PRIMARY CARE PHYSICIAN)

_____/_____/_____ F M S___M___D___W___O___ _____-_____-_____

DATE OF BIRTH **SEX** **MARITAL STATUS** **SOCIAL SECURITY #**

_____

EMPLOYER NAME

_____

RESPONSIBLE PARTY (IF NOT PATIENT)

_____ _____

NAME OF INSURANCE **INSURED'S NAME** (IF NOT PATIENT)

_____

INSURED'S ADDRESS (IF NOT THE SAME AS PATIENTS)

_____-_____-_____ _____-_____-_____ _____/_____/_____

INSURED'S PHONE **INSURED'S SS#** **INSURED'S DOB**

_____@_____

PATIENT'S EMAIL ADDRESS

HOW DID YOU HEAR ABOUT OUR OFFICE?_____

I accept responsibility as Guarantor for the above named patient. I authorize release of any medical information necessary to process claims for services rendered. I assign, transfer and set over to PERIMETER PLASTIC SURGERY, LLC all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize payment of these benefits to PERIMETER PLASTIC SURGERY, LLC. I accept responsibility for any balances unpaid by my insurance company

_____ _____/_____/_____

SIGNATURE OF PATIENT OR AUTHORIZED PERSON **DATE**