

NEW YORK-PRESBYTERIAN HOSPITAL
Division of Plastic and Reconstructive Surgery
Dr. Robert Grant, Chief

PATIENT'S NAME: _____ **UNIT#** _____

SS# _____ **DOB:** _____ **AGE:** _____ **SEX:** _____ **Marital Status:** _____

ADDRESS: _____ **EMPLOYER:** _____

TOWN/STATE/ZIP: _____ **BUSINESS ADD:** _____

TEL# _____ **TOWN/STATE/ZIP:** _____

CELL# _____ **BUSINESS TEL#:** _____

EMAIL: _____

REFERRAL SOURCE: _____

REFERRING M.D. _____ **TEL#:** _____

ADDRESS: _____ **TOWN/STATE/ZIP** _____

PRIMARY CARE PHYSICIAN _____ **TEL#** _____

ADDRESS: _____ **TOWN/STATE/ZIP** _____

Emergency Contact Name & Phone # _____

MOTHERS' FIRST NAME: _____ **FATHER'S FIRST NAME** _____

This is for medical record purposes only. Please enter names even if they are deceased.

PT. RELATIONSHIP TO GUARANTOR (CIRCLE ONE) SELF SPOUSE DEPENDENT CHILD STUDENT

PATIENT'S PRIMARY INSURANCE CO: _____ **Policy#** _____

GUARANTOR NAME: _____ **DOB:** _____ **SS#:** _____

PATIENT'S SECONDARY INSURANCE CO: _____ **Policy#** _____

GUARANTOR NAME: _____ **DOB:** _____ **SS#:** _____

AUTHORIZATION FOR TREATMENT

I hereby authorize you to give me reasonable and proper care by today's standards.

I hereby authorize and direct the above named clinical practice, having treated me, to release to governmental agencies, insurance carriers, or other who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

I hereby assign, transfer, and set over to the above named Clinical Practice sufficient moneys and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself and my dependent in said practice. I assume responsibility for charges that my insurance company does not cover.

I hereby authorize photography for medical purposes.

Date: _____ **Signature** _____
Signature of Patient or Authorized Representative

***I understand that the doctor is a non-participating provider of my insurance and therefore will be held responsible for any balances on account.**

Date: _____ **Signature** _____