# *The* PLASTIC SURGERY GROUP OF ROCHESTER

*Mark S. Davenport, MD • Jeffrey A. Fink, MD • Andrew W. Smith, MD, FACS • Brian D. Kubiak, MD , FACS*
*David Refermat, MD, FACS • Julie Sylvester, RPA-C*

Patient Name: _____ Date: _____

Address: _____ Date of Birth: _____

City: _____State:_____ Zip: _____ Sex: M F Age:_____

Marital Status: M S W D **Phone**: (Home) _____(Work)_____ (Cell)_____

Race: White / African American / American Indian /Alaska Native/ Asian/ Native Hawaiian/ Other Pacific Islander
Other / Declined

Ethnicity: Hispanic/ Non-Hispanic Declined_____

Preferred Language: English Other_____ Declined

Employer: _____ Occupation: _____

Employer's Address: _____

Spouse/Partner or Parent/Guardian Name: _____ Relationship _____Phone_____

Primary Care Physician: _____

Referring physician/person who sent you: _____

**INSURANCE INFORMATION** ********Copays are due at the time of service*******

**Primary**: Name of Insurance Co.: _____ Insurance ID#:_____

Subscriber's Name:_____ Subscriber's Birthdate: _____

Subscriber's Employer:_____ Relationship: _____

**Secondary**: Name of Insurance Co.: _____ Insurance ID#:_____

Subscriber's Name:_____ Subscriber's Birthdate: _____

Subscriber's Employer:_____ Relationship: _____

Were you treated in the Emergency Room/Urgent Care Center for this condition: Yes No
If yes which Hospital or Urgent Care Center: _____
Is this a work-related injury: Yes No
Does this visit relate to a motor vehicle accident

**www.rochesterplasticsurgery.com**

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*Rochester, NY 14621*
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*Unity Physicians Office Building*
*1561 Long Pond Rd., Suite 216*
*Rochester, NY 14626*
*(585) 368-4879*
*Fax: (585) 368-4345*

***Permission Regarding Communications***

Please check the following as you wish and sign at the bottom of the page:

Leave information regarding appointments:

| | |
|---|---|
| answering machine | ____ |
| cell phone/text | ____ |
| office voice mail | ____ |
| w/ another person | ____ |
| send through mail | ____ |
| send via e-mail/Portal | ____ |

Leave other medical info on:

| | |
|---|---|
| answering machine | ____ |
| cell phone/text | ____ |
| office voice mail | ____ |
| w/ another person | ____ |
| send through mail | ____ |
| send via e-mail/Portal | ____ |

E-mail address:_____

As a patient, you may choose whether to allow us to communicate information about your health status with the persons you list below. If you do not wish information about your health care to be shared with another individual, you do not have to complete this section.

I, _____, give permission to the Plastic Surgery Group of
(please print your name here)
Rochester to discuss information regarding my health with the following individuals:

Name of individual: _____

Telephone number: _____

Relationship to patient: _____

Name of individual: _____

Telephone number: _____

Relationship to patient: _____

Please sign Electronic Signature at Front Desk