

The
PLASTIC SURGERY GROUP OF ROCHESTER

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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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360 Linden Oaks, Suite 310
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(585) 922-5840
Fax: (585) 266-1083*

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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:

Leave other medical info on:

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

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