

Northwest Plastic Surgery Associates, PLLC

Patient Name _____ Birthdate _____ Age _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work _____ Cell _____
E-mail Address _____
Soc.Sec.# _____ - _____ - _____ Marital Status _____ Sex []Male []Female
Occupation _____ Employer _____
In Case of Emergency Please Contact _____ Phone _____
Referred by _____ Phone _____

**Please provide a current identification card along with current insurance card(s)
(If the patient is a minor please provide a parent/guardians current identification card) a copy will be
attached to your file. If the patient is a minor a parent/guardian must attend all appointments.
Guardians must provide legal documentation.**

PARENT/GUARDIAN INFORMATION IF PATIENT IS MINOR

Father/Guardian Name _____
Address(if different from patient's) _____
City _____ State _____ Zip _____
Home Phone _____
Mother/Guardian Name _____
Address(if different from patient's) _____
City _____ State _____ Zip _____
Home Phone _____

HEALTH INSURANCE INFORMATION

Primary Insurance _____
Insured Name _____ Soc.Sec.# _____
Birthdate _____ Policy ID# _____ Group# _____
Secondary Insurance _____
Insured Name _____ Soc.Sec.# _____
Birthdate _____ Policy ID# _____ Group# _____

ACCIDENT INFORMATION

Date of Accident _____ Worker's Comp [] Auto Accident [] Other [] _____
Insurance Carrier _____ Phone _____
Address _____ City _____ State _____ Zip _____
Claim or Policy # _____ Name of Adjustor _____

ASSIGNMENT AND RELEASE OF INFORMATION

NOTE: Insurance Pre-Authorization: It is the responsibility of the patient to notify this office if your insurance requires this for any services. Assignment and Release of Information: I hereby authorize NWPSA to release any information acquired in the course of my examination and treatment to the insurance company. I also authorize payment directly to the physician. **By signing below I recognize and accept responsibility for any balance remaining after payment of benefits.**

Signature _____ **Date** _____