

**PATIENT INFORMATION**

Last Name \_\_\_\_\_ Suffix \_\_\_\_\_ First Name & Initial \_\_\_\_\_  
Address \_\_\_\_\_  
City/State \_\_\_\_\_ Zip Code \_\_\_\_\_ Sex: Female / Male  
Employed Yes No Employer \_\_\_\_\_ Work Telephone # \_\_\_\_\_  
Home Telephone # \_\_\_\_\_ Cell Telephone # \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Marital Status \_\_\_\_\_  
Email Address \_\_\_\_\_ Would you like to receive our electronic newsletter? \* \_\_\_Yes \_\_\_No  
Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Referring Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Referral Sources: Times Union Spotlight Other Newspaper Radio TV Seminar Family/Friend Yellow Pages Website  
Physician Other (Please explain) \_\_\_\_\_  
Contact in case of emergency \_\_\_\_\_  
Relationship \_\_\_\_\_ Phone \_\_\_\_\_  
E-mail address \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION** (Insurance Subscriber) NOTE: Please complete this section if different from the patient information above.

Last Name \_\_\_\_\_ First Name & Initial \_\_\_\_\_  
Address \_\_\_\_\_  
City/State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Employed Yes No Employer \_\_\_\_\_ Work Telephone # \_\_\_\_\_  
Home Telephone # \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Marital Status \_\_\_\_\_  
Relationship to patient \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance \_\_\_\_\_ Subscriber ID # \_\_\_\_\_  
Group # \_\_\_\_\_ Copay \_\_\_\_\_  
Primary Insurance \_\_\_\_\_ Subscriber ID # \_\_\_\_\_  
Group # \_\_\_\_\_ Copay \_\_\_\_\_

**Is injury work related? Yes / No** If yes, please complete this section.

Date of injury \_\_\_\_\_  
Employer \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_  
Employer's Insurance Co. \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_

**Is injury related to car accident? Yes / No** If yes, please complete this section.

Date of injury \_\_\_\_\_  
Auto Insurance Subscriber \_\_\_\_\_ Phone # \_\_\_\_\_  
Auto Insurance Co. \_\_\_\_\_ Phone # \_\_\_\_\_  
Address \_\_\_\_\_

This form will be provided for your signature at your first office visit.

I HEREBY CONSENT TO THE FOLLOWING:

**AUTHORIZATION**

I authorize The Plastic Surgery Group, LLP to release all medical records pertaining to medical history, services rendered or treatment for me or my dependents for insurance claims.

I authorize payment of medical benefits to The Plastic Surgery Group, LLP.

I promise as guarantor for the above patient or as the patient, to pay for medical services at the time of service, unless prior arrangements have been made.

I understand that I am financially responsible for all charges incurred, whether or not they are covered/paid by my insurances.

**PERMISSION FOR TAKING PHOTOGRAPHS**

I hereby consent that photographs may be taken of me or the named patient by The Plastic Surgery Group, LLP in connection with the medical care and treatment received.

I give / do not give (circle one) permission for my photographs to be used for educational purposes.

**CONSENT TO RELEASE AND HIPAA ACKNOWLEDGEMENT**

I hereby authorize The Plastic Surgery Group, LLP to discuss my medical and payment information with:

1. \_\_\_\_\_ Relationship \_\_\_\_\_

2. \_\_\_\_\_ Relationship \_\_\_\_\_

2. \_\_\_\_\_ Relationship \_\_\_\_\_

I acknowledge that I have received a copy of The Plastic Surgery Group, LLP's notice of Privacy Practices. This notice describes how The Plastic Surgery Group, LLP may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

\_\_\_\_\_  
Patient / Guardian Signature

\_\_\_\_\_  
Date

\* Periodically we distribute the latest information on cosmetic surgery procedures, skin care products and services, and special savings offers. Your email address will never be shared or sold.