MARINA PLASTIC SURGERY

4644 Lincoln Blvd., Suite 552 • Marina del Rey, CA 90292
310.827.2653 • FAX 310.823.1984

PLEASE ANSWER ALL QUESTIONS

NAME _____ AGE _____ BIRTHDATE _____
last first middle initial

PATIENT'S SOCIAL SECURITY #_____ PATIENT'S DRIVER LICENSE#_____

HOME ADDRESS _____
street apt number

_____
city state zip code

HOME (_____)_____ CELL (_____)_____ WORK (_____)_____

BEST CONTACT NUMBER (Please circle one) HOME / CELL / WORK

E-MAIL_____

EMPLOYER_____ OCCUPATION_____

EMPLOYER ADDRESS _____
street city state zip code

NAME OF SPOUSE / PARENT / RESPONSIBLE PARTY (if other than patient)_____

HOME ADDRESS _____
street city state zip code

HOME (_____)_____ CELL (_____)_____ WORK (_____)_____

EMPLOYER_____ OCCUPATION_____

EMPLOYER ADDRESS _____
street city state zip code

NEAREST RELATIVE NOT LIVING WITH YOU_____

RELATIONSHIP _____ PHONE(_____)_____

REFERRED BY (Please circle one) MD / FRIEND / FAMILY / OTHER_____

PRIMARY PHYSICIAN_____

ADDRESS_____

REASON FOR CONSULTATION (LIST ALL)_____

SELF PAY

I do not have health insurance and will be responsible for services rendered here at Marina Plastic Surgery Associates. I agree to pay the full and entire amount for services rendered.

_____ _____
PATIENT/GUARANTOR SIGNATURE DATE

INSURANCE REIMBURSEMENT

NAME OF PATIENT'S PRIMARY INSURANCE CO _____

POLICY # _____ GROUP# _____

PATIENT STATUS (Please circle one) SINGLE / MARRIED / OTHER

PATIENT EMPLOYMENT STATUS (Please circle one) EMPLOYED / FULL-TIME STUDENT / PART-TIME STUDENT

NAME OF SUBSCRIBER (if other than patient) _____

RELATIONSHIP TO PATIENT (Please circle one) SPOUSE / PARENT / CHILD / OTHER

SUBSCRIBER SOCIAL SECURITY # _____ SUBSCRIBERS BIRTHDATE _____

SUBSCRIBER EMPLOYER/SCHOOL NAME _____

NAME OF SECONDARY INSURANCE CO _____

POLICY # _____ GROUP# _____

NAME OF SUBSCRIBER (if other than patient) _____

RELATIONSHIP TO PATIENT (Please circle one) SPOUSE / PARENT / CHILD / OTHER

SUBSCRIBER SOCIAL SECURITY # _____ SUBSCRIBERS BIRTHDATE _____

SUBSCRIBER EMPLOYER/SCHOOL NAME _____

STATEMENT OF FINANCIAL RESPONSIBILITY

The service(s) you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. If applicable and indicated, we will verify your coverage and bill your insurance carrier on your behalf, as a courtesy to you. However, you are ultimately responsible for payment of your bill in full.

PLEASE READ CAREFULLY: YOUR INSURANCE CARRIER MIGHT NOT FULLY REIMBURSE YOU FOR HOSPITAL ADMISSION OR SURGICAL PROCEDURES!

Most group insurance policies have just recently been amended to include preadmission certification requirements for hospital admissions and/or second surgical opinion requirements for selected surgical procedures. I understand that this is my responsibility to fulfill any preadmission or second opinion requirements contained in my insurance policy. I realize that failure to do so may result in a significant reduction in my insurance benefits. I, the undersigned, have read the above policy regarding my financial responsibility to Marina Plastic Surgery, for providing services to me or the patient mentioned below. I certify that the information, to the best of my knowledge, true and accurate. I hereby assign Marina Plastic Surgery all payments to which I am entitled for medical and/or surgical expenses related to the services reported for my illness or injury. I understand that I am financially responsible to said provider for charges not covered by this assignment of benefits. A copy of this assignment is as valid as the original.

_____ _____

PATIENT (PRINT NAME) DATE

_____

PATIENT SIGNATURE

_____ _____

GUARANTOR/SUBSCRIBER if patient is a minor (PRINT NAME) DATE

_____

GUARANTOR/SUBSCRIBER SIGNATURE (if patient is a minor)