DEMOGRAPHIC SHEET

PATIENT NAME: ____

BIRTH DATE: ___/____/________ **AGE:** ________ **SOCIAL SECURITY:** _______________________

PATIENT ADDRESS: ____

CITY: _____________________________ **STATE:** _______ **ZIP CODE:** ___________________

HOME PHONE: ______________________ **CELL PHONE:** _______________________________

EMAIL ADDRESS: ____

MARITAL STATUS: __________ **SPOUSE'S FULL NAME:** __________________________________

PATIENT'S EMPLOYER NAME/OCCUPATION:

____

WHO REFERRED YOU TO OUR PRACTICE? ____

REASON FOR TODAY'S VISIT: ____

RESPONSIBLE PARTY'S INFORMATION

NAME: _____________________________ **PHONE NUMBER:** _______________________________

RELATIONSHIP TO PATIENT: SELF / SPOUSE / PARENT **DATE OF BIRTH:** _____/______/_________

--**Please initial in the space provided to the left.** ***If not applicable, please write N/A***

________I hereby give authorization for payment of insurance benefits to be made directly to the PLASTIC SURGERY CENTER OF NASHVILLE, PLLC, and any assisting physicians, for services rendered.

________ I hereby authorize this healthcare provider to release all information to secure the payment of benefits. I further agree that a photo copy of this agreement shall be valid as the original.

________ I hereby authorize THE PLASTIC SURGERY CENTER OF NASHVILLE, PLLC to release information requested by my insurance company necessary to process claims for consideration of benefits and payment.

________ I hereby authorize THE PLASTIC SURGERY CENTER OF NASHVILLE, PLLC to release information to any hospital or physician on referral by the office

I understand that I am financially responsible for all charges, whether or not they are covered by insurance. In the event that my account should become delinquent, I agree to pay all costs of collection and reasonable attorney's fees.

SIGNATURE: ____ **DATE:** ____/______/________ **RELATIONSHIP TO PATIENT:** SELF / SPOUSE / PARENT