GALLAHER
GALLAHER PLASTIC SURGERY & SPA MD

Today's Date: _____ Chart #: _____

PATIENT INFORMATION

Last Name: _____ MI: _____ First Name: _____ ☐ M ☐ F

Address: _____ City: _____ St: ____ Zip: _____

Home Phone: ( )_____ Work Ph: ( ) _____ Cell Ph: ( )_____

Age: _____ Date of Birth: _____ Social Security #: _____

Patient Employer: _____

Marital Status: ☐ S ☐ M ☐ W ☐ D Spouse's Name:_____

Spouse's Date of Birth: _____ Spouse's Social Security #: _____

Spouse's Employer: _____ Work Phone: ( ) _____

Emergency Contact: _____ Phone: ( ) _____

REFERRAL INFORMATION

Referring Physician: _____ Phone: ( ) _____

Primary Care Physician: _____ Phone: ( ) _____

How were you referred to our office?: _____

MARKETING ACKNOWLEDGMENT

As a patient of Gallaher Plastic Surgery, please check the response that applies to you.

☐ I would like information, via mail or email, about new products, services or events.
Email Address:_____

☐ I would not like to receive information, via mail or email, about new products or services.

Signature: _____ **Date:** _____

AUTHORIZATION FOR PHOTO RELEASE

I understand that photography is a necessary part of planning and evaluating cosmetic or reconstructive surgery. I authorize the taking of photographs and the release of such photographs at the direction of my surgeon and under such conditions as may be approved by him/her. These photographs will be used solely for documentation purposes and will be kept confidential.

Signature: _____ **Date:**_____

RESPONSIBLE PARTY INFORMATION

Relation to Patient: ☐ Self (if self skip this area) ☐ Parent ☐ Guardian

Father's Name: _____

Address: _____ City: _____ St: ____ Zip: _____

Home Phone: ( )_____ Social Security #:_____ Date of Birth: _____

Employer Address: _____ Work Phone: ( ) _____

Relation to Patient: ☐ Parent ☐ Guardian

Mother's Name: _____

Address: _____ City: _____ St: ____ Zip: _____

Home Phone: ( )_____ Social Security #:_____ Date of Birth: _____

Employer Address: _____ Work Phone: ( ) _____

INSURANCE POLICY HOLDER

Primary Insurance Carrier: _____

Relation to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian

Social Security #: _____ Date of Birth: _____ Name:_____

Secondary Insurance Carrier: _____

Relation to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian

Social Security #: _____ Date of Birth: _____ Name:_____

INSURANCE AUTHORIZATION AND ASSIGNMENT

All professional service rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. I understand that I am responsible for any amount not covered by my insurance.

I authorize the release of any medical information necessary to process insurance claims filed on my behalf or on behalf of my dependents.

Signature: _____ **Date:**_____

I authorize payment of medical benefits to be made directly to the supplier or physician for services rendered.

Signature: _____ **Date:**_____

Medicare Only

I request that payment of authorized Medicare benefits be made either to me or on my behalf to my physician for services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signature: _____ **Date:**_____