PATIENT INFORMATION

Patient Name: _____

Address:_____

City:_____ State:_____ Zip:_____

Date of Birth:_____ Social Security Number: _____-_____-_____

Age:_____ Sex: Female/ Male Marital Status:_____

Primary Language English: Yes or N0 Other:_____

Whom can we thank for the referral?_____

How May We Contact You?	May We Call?	May We leave a message?
Home Number: _____	yes or no	yes or no
Work Number:_____	yes or no	yes or no
Cell Number:_____	yes or no	yes or no

Emergency Contact: _____ Number:_____

Relationship to You:_____

By Proving your email address, you give permission to receive product information from MTPS.

Email Address:_____

Employer Information:

Employer Name:_____

Work Address:_____

City:_____ State:_____ Zip:_____

Supervisor:_____Phone:_____

Insurance Policy Holder Date of Birth:_____ Relationship to Insured:_____

Pharmacy Information:

Name:_____

Address:_____

City:_____ State:_____ Phone:_____

Consent for Treatment and Limited Disclosure of Protected Health Information

I have been provided with a "Notice of Privacy Practices". I consent to treatment, and recognize that my private health information may be released to obtain payment from third party payers or to facilitate medical treatment. I consent to photography and use of such photography, without identifiable patient information, for any purpose deemed appropriate by Middle Tennessee Plastic Surgery, P.C.. I recognize that I may be responsible for payment of a portion or all costs associated with evaluation and treatment, depending on the provisions of my insurance policies and those of TN state law. In the event legal action is required to obtain payment, I agree to pay reasonable and necessary costs incurred by Middle Tennessee Plastic Surgery, P.C., including but not limited to attorney's fees and court costs.

_____ _____

Patient or Authorized Legal Representative Date