The Plastic Surgery Clinic, PA
1419 Wesport Landing Place, Suite 101 Manhattan, KS 66502

Dr. Kenneth A. Fischer
785-776-7500 phone 785-770-8558 fax

⌘ Patient Information ⌘

Name: Social Security Number:
Last First Middle Init.

Address:

City: State: Zip: E-mail Address:

Home Phone: Daytime (Work) Phone: Cell Phone:

Date of Birth: Age: Male / Female Marital Status: Single, Married, Divorced, Widowed, Separated

Emergency Contact Information:

Name:

Address:

Phone: Cell Phone:

Relationship to Patient: Parent, Spouse, Child, Other:_____

Alternate Contact (not living in your household):

Name:

Address:

Phone: Cell Phone:

Relationship to Patient: Parent, Spouse, Child, Other:_____

Employment Status: Full Time, Part Time, Self Employed, Retired, Unemployed, Military, Student

Employer: Phone: Employer's Address

Injury Information: Is the reason for your visit injury related? Yes No Date of Injury:_____

Where were you injured? Home, School, During Recreation, Work Injury, Motorcycle Injury, Auto Accident

How will you be paying for your medical expenses? Insurance Self Pay Worker's Comp

Insurance Information:

Primary Insurance Company: Policy#: Group#:

Policy Holders Name (Subscriber): Relationship to Policy Holder: Self Spouse Child

Phone Number of Policy Holder : Policy Holder's SSN & DOB:

Secondary Insurance Company: Policy#: Group#:

Policy Holders Name (Subscriber): Relationship to Policy Holder: Self Spouse Child

Phone Number of Policy Holder : Policy Holder's SSN & DOB:

If there are any other Insurance Companies please list on back.

Worker's Compensation Information:

Name of Company: Contact Person: Phone:

Address:

⌘ Assignment and Release ⌘

⌘ I hereby authorize The Plastic Surgery Clinic to release information and photographs acquired in the course of my examination or treatment, including information necessary for medical insurance authorization, medical record requirements and educational purposes.

⌘ I hereby authorize any physician, hospital or medical care facility to provide information on my medical history and treatment to The Plastic Surgery Clinic.

⌘ I understand that I am financially responsible for all charges for my medical care. In the event of default, I agree to pay all costs of collection, and reasonable attorney fees.

⌘ I hereby give lifetime authorization for payment of insurance benefits to be made directly to The Plastic Surgery Clinic, and any assisting physicians for services rendered. I understand that I am finically responsible for all charges whether or not they are covered by insurance. ***(Pertains to patients filing with insurance only)***

⌘ I hereby authorize the above listed insurance companies to pay directly to The Plastic Surgery Clinic benefits due me, if any, as provided in the above un-expired policy. I will pay all charges in excess of whatever sums may be paid. I authorize The Plastic Surgery Clinic to release information to the insurance company for my claims to be paid. ***(Pertains to patients filing with insurance only)***

Responsible Party Signature: Relationship to Patient: Date: