CORNERTSTONE PLASTIC SURGERY

BY FREDERICK A. COVILLE, MD

In order for our office to best prepare for your visit, please complete the information below.

PATIENT INFORMATION

Confidential Information: The information herein will not be released except when you have authorized us to do so. This information will be used by the doctor in his decisions regarding your care.

How did you hear about our office?_____ Today's date:_____

Patient's Name:_____ Marital Status:_____ Sex:_____

Parent/Guardian's name *(for minors):*_____

Home Address:_____

City:_____ State: _____ Zip:_____

Home Phone #: _____ Mobile: _____ Work:_____

Email:_____ *Is this okay to use?* ☐Yes ☐No

Date of birth:_____ Social Security Number: _____

Age:____ Height:_____ Weight: _____ Pharmacy name and town:_____

Occupation:_____

Employer (if patient is a minor, parent's place of employment):_____

Emergency contact name:_____ Relationship:_____

Home Phone #: _____ Mobile: _____ Work:_____

Primary care physician name, city, and town:_____

Primary insurance:_____ Policy number:_____

Secondary insurance:_____ Policy number:_____

Assignment of Benefits:

I, the undersigned, hereby authorize payment of medical and surgical benefits directly to Frederick A. Coville, MD, PC (Cornerstone Plastic Surgery and Aesthetic Medicine).

I, the undersigned, assign directly to Frederick A. Coville MD, PC all benefits, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I authorize the use of my signature on all my insurance submissions. I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies, (including Medicare) for purpose of filing payment of medical claims. All court fees, interest fees, or other fees necessary to collect this amount are payable by me. I permit a copy of this release to be used in place of the original.

Name (printed):_____

Signature of insured or responsible party:_____

Date:_____