INSTITUTE OF PLASTIC SURGERY IN SAN ANTONIO, PA

Patient Information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ e-mail address _____

Reason for visit **Whom may we thank for referring you?** _____

Age _____ Birth date _____ SS# _____ Sex ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: _____ ❒ Other: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
Street & Suite # City State Zip

Your Pharmacy Name: _____ **Pharmacy Phone#** _____

Emergency Contact
(Not in your household) _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____
Street & Apt # City State Zip

Primary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Insured: Name _____ DOB _____ **SS #** _____

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Ayala to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Ayala and myself. I further understand that any charges I incur in this office may be subject to additional service fees should my account become delinquent.

Signature _____ **Date** _____