Arkoulakis Plastic Surgery

PATIENT INFORMATION (PLEASE PRINT)

PATIENT'S FULL NAME	REFERRED BY	DATE

DATE OF BIRTH	AGE	SEX	MARITAL STATUS	SOCIAL SEC. NO.

STREET ADDRESS	CITY, STATE, ZIP CODE	HOME PHONE
PATIENT'S EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	CELL OR PAGER #
EMPLOYER'S STREET ADDRESS	CITY, STATE, ZIP CODE	BUSINESS PHONE

SPOUSE OR PARENT'S NAME	DATE OF BIRTH	SOC. SEC. NO.	HOME PHONE

SPOUSE OR PARENT'S EMPLOYER	OCCUPATION	BUSINESS PHONE
EMPLOYER'S STREET ADDRESS	CITY, STATE, ZIP CODE	

RESPONSIBLE PARTY INFORMATION

NAME OF RESPONSIBLE PARTY	DATE OF BIRTH	SOC. SEC. NO.	RELATIONSHIP

STREET ADDRESS	CITY, STATE, ZIP CODE	HOME PHONE
RESPONSIBLE PARTY'S EMPLOYER	OCCUPATION	BUSINESS PHONE
EMPLOYER'S STREET ADDRESS	CITY, STATE, ZIP CODE	

INSURANCE INFORMATION

NAME OF PRIMARY INSURANCE COMPANY	CONTRACT NO.	GROUP NO.	NAME AS IT APPEARS ON CARD
NAME OF SECONDARY INSURANCE COMPANY	CONTRACT NO.	GROUP NO.	NAME AS IT APPEARS ON CARD

ARE YOU INSURED UNDER YOUR SPOUSE'S INSURANCE?	YES ☐ NO ☐	IF YES, NAME OF INSURANCE COMPANY	CONTRACT NO.	GROUP NO.
WERE YOU INJURED IN A MOTOR VEHICLE ACCIDENT?	YES ☐ NO ☐	DATE OF MOTOR VEHICLE ACCIDENT	STATE	

IN CASE OF EMERGENCY NOTIFY

NAME	RELATIONSHIP	PHONE NO.
STREET ADDRESS	CITY, STATE, ZIP CODE	

PATIENT STATEMENT

I hereby authorize treatment by Dr. Arkoulakis and his associates. I have received the notice of privacy practices from Dr. Arkoulakis' office.

I hereby authorize release of any and all information acquired in my evaluation and treatment to my insurer(s) listed above for the purpose of filing claims on my behalf. I agree to furnish my insurance card, driver's license, and any necessary forms to this office.

I hereby assign and authorize payment directly to Dr. Arkoulakis. I agree to assign any insurance benefits otherwise payable to me directly to Dr. Arkoulakis, should an insurance payment be received that is less than the physician's usual charge for the services provided. I understand that if Dr. Arkoulakis does not participate in my insurance plan, then I will be personally responsible for payment of any difference between insurance reimbursement and his usual and customary fee. I also agree to pay all costs of collection including, but not limited to reasonable attorney's fees, and waive all claims of exemption under the laws of the state of New Jersey.

** Form must be signed and dated by patient or legal guardian

Signed: ____________________________________ Date: ___________________