The Abel Center for Oculofacial Plastic Surgery

New Patient Form

Patient Name:_____ DOB: _____ /_____ /_____

Today's Date: _____ /_____/_____ Sex: M / F SSN: _____ - _____ - _____

Race: _____ Ethnicity: Hispanic or Latino / Not Hispanic or Latino
Language:_____

Relationship Status (please circle): Single / Married / Widowed / Divorced

Address:_____

City:_____ State: _____ Zip Code: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Work Phone: (_____)_____ - _____ Email: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: (_____) _____ - _____

Occupation: _____ Employer:
_____

Spouse Name: _____ DOB: ____/_____/_____ SSN: _____ - _____ -
_____

Family Physician: _____ Phone: (_____) _____ -
_____

Ophthalmologist: _____ Phone: (_____) _____ -
_____

Cardiologist: _____ Phone: (_____) _____ -
_____

Name of Referring Physician/Ophthalmologist: _____

Primary Insurance: _____ Guarantor: _____

Secondary Insurance: _____

Guardian/ Parent Information (If Patient a Minor)

Name: _____ SSN: _____ - _____ - _____ DOB: _____ /_____ /_____

Home/Work Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

I hereby authorize my examinations, including dilation, during the course of diagnosis and treatments. I hereby authorize payment directly to The Abel Center for Oculofacial Plastic Surgery , LLC for all benefits payable to me under these terms of insurance policy for treatment of services provided to my dependents or me. I authorize the release of any medical information necessary to process such insurance claims. I understand that I am financially responsible for any balances or charges not covered by my insurance(s). I hereby authorize release of any medical information and/or taxes regarding my treatment:

Patient Name: _____ DOB: _____/_____/_____

Name of person or persons: _____ Date: _____/_____/_____

Signature:_____