MEININGER PLASTIC SURGERY
PATIENT DEMOGRAPHICS

Print Legibly

Patient's Name: First:_____ Last:_____ MI:_____

Address _____
Street & Apt # City State Zip

Age _____ Birthdate____/____/_____ SS#: _____-_____-_____ Sex ☐ Female ☐ Male

☐ Single ☐ Married Spouse/Partner: _____ ☐ Other _____

Home #: _____[ ]Cell #: _____[ ]Other # _____[ ] **Please [✓]preferred contact #**

Okay to be notified by text of appointment reminders on mobile device [ ]

E-mail _____ Driver's License #: _____ State _____

Emergency Contact _____ Relationship to Pt: _____
(Not in your household)

Phone # _____ Address: _____

Patient's Employer _____ Occupation_____

Work Phone _____Ext: _____ Is it okay to call you at work? ☐ No ☐ Yes

RACE: ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ Hispanic ☐ Other_____ LANGUAGE: ☐ English ☐ Spanish ☐Other_____
Race is a federal requirement mandated by CMS-Centers for Medicare & Medicaid Services – Appropriate Box(s) must be marked

Referred By: _____

Phone # _____ Address: _____

Primary Care Physician _____

Phone # _____ Address: _____

Primary Health Insurance Company:_____

Policy #: _____Group #: _____ Copay? ☐ No ☐ Yes $_____ Referral Required? ☐ No ☐ Yes

Subscriber: Name: _____ DOB: ____/____/____ Subscriber SS#: _____-_____-_____

Secondary Health Insurance Company _____

Policy #: _____Group #: _____ Copay? ☐ No ☐ Yes $_____ Referral Required? ☐ No ☐Yes

Subscriber: Name: _____ DOB: ____/____/____ Subscriber SS#: _____-_____-_____

Phone # _____ Address: _____

Authorization to pay benefits to physician and release of medical information: I hereby authorize payment directly to Michael S. Meininger, M.D., of any surgical and/or medical benefits otherwise payable to me for his services. I hereby authorize Dr. Meininger to release any medical information necessary for payment on my insurance claim. I understand I am responsible for payment of all copays and deductibles as required by my insurance company.

Signature _____ **Date** _____