RICHARD D. ZEPH, M.D.F.A.C.S.
FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY
13590-B NORTH MERIDIAN STREET, SUITE 201
CARMEL, IN 46032
(317) 573-7887 OR (800) 352-1056 WWW.ZEPHCOSMETICSURGERY.COM

PATIENT INFORMATION SHEET

DATE: _____

NAME: _____ DATE OF BIRTH_____ M OR F
FIRST MIDDLE LAST

ADDRESS:_____AGE:_____PATIENT SS#_____
STREET/ P.O. BOX CITY STATE ZIP CODE

HOME PHONE: _____ EMPLOYER NAME: _____ WORK PHONE: _____

S / M / W / D SPOUSE NAME: _____EMPLOYER NAME: _____ WORK PHONE: _____

IF PATIENT IS UNDER 18 YEARS OF AGE, PLEASE LIST PARENTS NAME, ADDRESS, & EMPLOYER.

MOTHER/FATHER NAME: _____ADDRESS: _____

EMPLOYER – MOTHER: _____ DAYTIME PHONE: _____

EMPLOYER – FATHER: _____DAYTIME PHONE: _____

IN CASE OF EMERGENCY, PLEASE LIST NAME, PHONE NUMBER AND RELATIONSHIP OF PERSON(S) TO CONTACT:

NAME: _____RELATIONSHIP: _____PHONE: _____

NAME: _____RELATIONSHIP: _____PHONE: _____

ACCIDENT RELATED? YES / NO DATE OF ACCIDENT: _____PLACE OF ACCIDENT: _____

REFERRING PHYSICIAN: _____ADDRESS: _____

INSURANCE INFORMATION: In order to assist you in the sometimes difficult and time consuming task of completing medical insurance forms, we need the following completed in it's entirety. **In addition to this form, please have your insurance card and driver's license out for the receptionist to copy**. Thank you for your cooperation.

PRIMARY INSURANCE: *(IF MORE THAN ONE INSURANCE – COMPLETE SECONDARY INSURANCE INFORMATION)*

NAME OF INSURANCE: _____

ADDRESS: _____ CITY & STATE: _____ZIP CODE: _____

TELEPHONE NO. TO VERIFY BENEFITS AND PRE-CERTIFICATION: _____

_____ INSURED DATE OF BIRTH: _____

NAME OF INSURED: _____EMPLOYER: _____

RELATIONSHIP TO INSURED: SELF (1) _____SPOUSE (2) _____CHILD (3)_____OTHER (4)_____

EMPLOYERS ADDRESS: _____PHONE NO._____

ID/SS NUMBER: _____ POLICY/GROUP NUMBER_____

SECONDARY INSURANCE NAME: _____

ADDRESS: _____CITY & STATE: _____ZIP CODE: _____

TELEPHONE NO. TO VERIFY BENEFITS AND PRE-CERTIFICATION: _____

_____INSURED DATE OF BIRTH: _____

NAME OF INSURED: _____EMPLOYER: _____

RELATIONSHIP TO INSURED: SELF (1) _____SPOUSE (2) _____CHILD (3)_____OTHER (4)_____

EMPLOYERS ADDRESS: _____PHONE NO. _____

ID/SS NUMBER: _____POLICY/GROUP NUMBER_____

-PLEASE SIGN AUTHORIZATION STATEMENT ON BACK –

IF THE HOSPITAL OR OUR OFFICE SHOULD NEED TO CONTACT YOU, AT WHAT NUMBER(S) CAN YOU BE REACHED?

_____

DO THEY/ WE HAVE YOUR PERMISSION TO LEAVE A MESSAGE ON THE VOICEMAIL/ANSWERING MACHINE?

_____

DO THEY/WE HAVE YOUR PERMISSION TO SPEAK WITH YOUR SPOUSE/FAMILY MEMBER/SIGNIFICANT OTHER?

_____

I ACKNOWLEDGE I AM FINANCIALLY RESPONSIBLE FOR ANY SERVICES RENDERED BY RICHARD D. ZEPH, M.D.

SIGNATURE:_____DATE_____

(IF APPLICABLE) SIGNATURE OF PARENT OF MINOR CHILD OR LEGAL GUARDIAN OF PATIENT:

SIGNATURE:_____DATE:_____

MEDICAL INSURANCE RELEASE

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION INCLUDING PHOTOGRAPHS NECESSARY TO PROCESS ANY CLAIM FOR SERVICES PROVIDED BY DR. ZEPH. I FURTHER AUTHORIZE THE RELEASE OF MEDICAL BENEFITS TO DR. ZEPH. A COPY OF THIS AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL. I UNDERSTAND THE DOCTOR'S CHARGES MAY EXCEED MY INSURANCE CARRIERS ALLOWABLE PAYMENT, AND IF THIS SHOULD OCCUR, I REALIZE I WILL BE RESPONSIBLE FOR THAT PORTION. **ALL OF THE FOLLOW UP APPOINTMENTS WILL BE COVERED UNDER THE INITIAL SURGERY FEE FOR THE FIRST 60 DAYS. AFTER THAT TIME PERIOD, YOUR INSURANCE WILL BE BILLED APPROPRIATELY.**

SIGNATURE:_____DATE:_____

(IF APPLICABLE) SIGNATURE OF PARENT OF MINOR CHILD OR LEGAL GUARDIAN OF PATIENT:

_____DATE:_____