

Pacific Plastic Surgery

a medical corporation

Douglas J. Mackenzie, M.D.

PATIENT INFORMATION

NAME _____ Birth date: ___/___/___ Age : _____ Sex: M / F
LAST FIRST MIDDLE INITIAL

HOME ADDRESS _____
STREET CITY STATE ZIP

E MAIL ADDRESS _____

WORK TELEPHONE _____ HOME PHONE _____ CELL PHONE _____

BEST PHONE _____ **PREFERED CONTACT METHOD** _____ **MAIL OKAY? YES / NO**

EMPLOYER _____ OCCUPATION _____

SOCIAL SECURITY # _____ DRIVERS LICENSE # _____

MARITAL STATUS: **M S W D** NAME OF SPOUSE _____ DOB _____ S/S# _____

REASON FOR VISIT _____

REFERRED BY: _____ PRIMARY CARE DOCTOR _____

NEAREST RELATIVE _____ RELATIONSHIP _____ PHONE # _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE # _____

INSURANCE INFORMATION

THIS OFFICE IS NOT A CONTRACTED PROVIDER

INSURANCE COMPANY _____

ID# _____ GROUP/CLAIM/AUTH # _____

CLAIMS NAME & ADDRESS _____

CLAIMS ADJUSTER _____ PHONE # _____

SUBSCRIBER'S NAME IF DIFFERENT _____

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY MEDICAL CLAIM. I AUTHORIZE PAYMENT OF MEDICAL AND SURGICAL BENEFITS DIRECTLY TO DOUGLAS J. MACKENZIE, M.D., HOWEVER, I ACCEPT FINANCIAL RESPONSIBILITY FOR CHARGES NOT COVERED BY MY INSURANCE OR THIS AUTHORIZATION. I ALSO AUTHORIZE THAT A PHOTGRAPHIC COPY OF THIS DOCUMENT IS AS IF SUCH COPY WERE THE ORIGINAL. A FINANCE CHARGE MAY BE ASSESSED ON THE UNPAID BALANCE FOR ALL ACCOUNTS 90 DAYS PAST DUE. **** I ALSO UNDERSTAND THAT DR. MACKENZIE IS NOT A PREFERED PROVIDER UNDER MY INSURANCE PLAN.**

DATE _____ **SIGNED** _____

RELATIONSHIP IF PARENT OR GUARDIAN _____