

PATIENT INFORMATION

DATE

PATIENT NAME

LAST

FIRST

MIDDLE

ADDRESS

DATE OF BIRTH

CITY

STATE
AGE

ZIP CODE
SEX

SOCIAL SECURITY #

MARITAL STATUS

HOME PHONE

WORK PHONE

CELL PHONE

E-MAIL ADDRESS

EMPLOYER/OCCUPATION

EMERGENCY CONTACT PERSON/PHONE #

PRIMARY CARE DOCTOR/PHONE #

WHY ARE YOU SEEING DR BARBER TODAY (DATE OF INJURY)? HOW WERE YOU REFERRED?

LIST OTHER DOCTORS YOU HAVE CONSULTED WITH REGARDS TO THIS CONDITION.

HEIGHT/WEIGHT

ARE YOU A SMOKER?

CURRENT MEDICATIONS/DOSAGE

ALLERGIES

PLEASE LIST ALL HEALTH PROBLEMS & ANY PAST HISTORY OF MRSA

PLEASE LIST ALL OPERATIONS/YEAR/SURGEON

PRIMARY INSURANCE (N/A IF COSMETIC)

NAME

ID #

GROUP #

NAME INSURANCE IS UNDER

PATIENT'S RELATIONSHIP TO INSURED

DATE OF BIRTH

ADDRESS

PHONE

SOCIAL SECURITY #

EMPLOYER

SECONDARY INSURANCE

NAME

ID #

GROUP #

NAME INSURANCE IS UNDER

DATE OF BIRTH

PATIENT'S RELATIONSHIP TO INSURED

ADDRESS

PHONE

SOCIAL SECURITY #

EMPLOYER

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I authorize the release of medical information necessary to process my claim. I also authorize payment of medical benefits to James Barber, M.D. for services provided. I understand that it is my responsibility to get all referrals/authorizations for services provided. I agree to pay any applicable out-of-pocket expenses as required by my insurance company. I also understand that it is my responsibility to go to a provider that participates with my healthcare.

I hereby authorize James Barber, M.D. to utilize photos of necessary surgical site, before and after surgery for the purpose of surgical results. I understand my name will remain confidential. I authorize the use of my testimonial for marketing purposes. I understand my name will remain confidential.

I understand that the office may send marketing/promotional information to my home/work e-mail. Dr. Barber's office cannot guarantee that e-mail communications will be confidential.

I acknowledge all the information provided to be complete and accurate.

SIGNATURE/DATE