KEVIN I. PERMAN, MD P.C.

THE CENTER FOR EYELID AND FACIAL PLASTIC SURGERY, LLC.

PATIENT REGISTRATION

LAST NAME:______________________ FIRST NAME:______________________ MI:__________

ADDRESS: ____

City______________________ State__________Zip Code______________

HOME PHONE: ______________ WORK PHONE: ______________ CELL PHONE: ______________

DATE OF BIRTH: ______________ SOCIAL SECURITY NUMBER: ______________________

EMAIL ADDRESS: ______________________________________

STATUS: *Married* *Single* *Divorced* *Widowed* GENDER: *Male* *Female*

EMPLOYER: ______________________________ JOB TITLE: ______________________

WORK ADDRESS: ____

REFERRING PHYSICIAN: ______________________________ PHONE: ______________

PRIMARY CARE PHYSICIAN: ______________________________ PHONE: ______________

OTHER PHYSICIAN: ______________________________ PHONE: ______________

EMERGENCY CONTACT NAME: ______________________________ RELATIONSHIP: ______________

ADDRESS: ____

HOME PHONE: ______________ WORK PHONE: ______________ CELL PHONE: ______________

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: ______________________________________

ADDRESS: ______________________________ PHONE: ______________

SUBSCRIBER'S NAME: ______________________________ RELATIONSHIP: *Self* *Spouse* *Parent*

SUBSCRIBER'S DATE OF BIRTH: ______________ SUBSCRIBER'S SS#: ______________

ID NUMBER: ______________________________ GROUP NUMBER; ______________

SECONDARY INSURANCE COMPANY: ______________________________________

ADDRESS: ______________________________ PHONE: ______________

SUBSCRIBER'S NAME: ______________________________ RELATIONSHIP: *Self* *Spouse* *Parent*

SUBSCRIBER'S DATE OF BIRTH: ______________ SUBSCRIBER'S SS#: ______________

ID NUMBER: ______________________________ GROUP NUMBER; ______________

I request that payment of authorized benefits (including Medicare) be made on my behalf to Kevin I. Perman, M.D., PC . or The Center for Eyelid and Facial Plastic Surgery, LLC. for any services furnished to me by physician or supplier. I authorize the release of any medical information necessary to process claims. I permit a copy of this authorization to be used in place of the original. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I certify that the information I have reported with regard to my insurance coverage is correct. Either my insurance company or I may revoke this authorization at any time in writing. I understand that I am financially responsible for all charges, whether or not paid by my insurance. I further understand that I will be responsible for any additional charges that are incurred on my behalf (including bank charges, attorney fees and collection fees.)

I hearby authorize said assignee to release all information necessary to secure this payment.

SIGNATURE: ______________________________ **DATE:** ______________

For office use: