

## Patient Information

Date \_\_\_\_\_ Birth Date \_\_\_\_\_ Please list all current medical conditions:

Name \_\_\_\_\_ 1.

Sex \_\_\_ Marital Status S \_\_\_ M \_\_\_ W \_\_\_ D \_\_\_ P \_\_\_ 2.

**Email Address** \_\_\_\_\_ 3.

Street \_\_\_\_\_ 4.

City/State/Zip \_\_\_\_\_ Please list all current medications:

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ 1. 4.

Employer/Occupation \_\_\_\_\_ 2. 5.

Phone \_\_\_\_\_ 3. 6.

Personal Physician \_\_\_\_\_

Referring Physician \_\_\_\_\_ Allergies \_\_\_\_\_

Other Referral \_\_\_\_\_ Have you ever had Hepatitis? Yes \_\_\_ No \_\_\_

Person Responsible for Bill \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

### INSURANCE INFORMATION

Company	ID Number	Group Number
1. _____	_____	_____

2. _____
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My Relationship to Insured: Self \_\_\_ Spouse \_\_\_ Child \_\_\_ Other \_\_\_

If the insurance is in someone else's name, please fill in:

Name of Insured Person \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

I authorize the release of medical information necessary to process claims for medical benefits. I authorize payment of medical benefits to Edward H. Stolar, MD, PC and Todd E. Perkins, MD, for services provided. I agree to pay Edward H. Stolar, MD, PC and Todd E. Perkins, MD, all co-payments, coinsurance, deductibles and any non-covered services as stipulated under my insurance plan. Non-covered services include cosmetic procedures not medically necessary and any service that has not been authorized by my insurance company. **I understand that there will be a \$50 charge for missed office visits and \$100 charge for missed surgical appointments if notice is not given a full business day before the appointment.**

Signed \_\_\_\_\_ Date \_\_\_\_\_