Washington Plastic Surgery Group, L.L.C.

Barry J. Cohen, M.D., P.C. **Adam G. Tattelbaum, M.D., P.C.** **Bennett C. Yang, M.D., P.C.** **Frederick H. Watkins, M.D.**

1. ______________________________
PATIENT'S FIRST NAME (Nombre) **MIDDLE INITIAL** **LAST NAME (Apellido)**

2. ______________________________
STREET ADDRESS(Direccion)

____
CITY (Ciudad) **STATE (Estado)** **ZIP (Codigo Pasta)**

Social Security Number
(Seguro Social #): ______________________________

Date of Birth
(Fecha de Nacimiento): ____/____/____

Age (Edad): ________ Sex: M / F Marital Status: Married / Single Date of Injury: ____/____/____

Home Phone Number
(de Telefono de Su Hogar): (____)__________
Can we contact you at home: Yes / No

Cell Phone Number
(Numero de celular): (____)__________
Can we contact your cell phone: Yes / No

Work Phone (Trabajo): (____)__________
Can we contact you at work: Yes / No

Email: ______________________________
Can we contact you via email: Yes / No

____
Employer (Compania):

____
Referred from: (Referericial) ER, Internet, Friend, etc

____
Reason for Office Visit: Please specify injury and affected area. If cosmetic, specify procedure(s)

______________________________ (____)__________
PRIMARY INSURANCE Company Name and Address **Phone Number**

Primary Insurance Policy or I.D. Number:______________________________ **GroupNumber:**__________

______________________________ (____)__________
SECONDARY INSURANCE Company Name and Address **Phone Number**

Secondary Insurance Policy or I.D. Nmber:______________________________ **GroupNumber:**__________

Spouse/Parents Name (Responsible Party): ______________________________ Phone Number: (____)__________

****IF WORKER'S COMP**:**

Employer (Compania): ______________________________ Work # (Trabajo): (____)__________

Work Address: ______________________________ Date of Injury: ____/____/____

______________________________ Point of Contact: ______________________________

Claim Number: ______________________________

****IF THIS IS AN ATTORNEY CASE**:**

Attorney Name: ______________________________ Phone Number: (____)__________

Attorney Address: ______________________________

____

I hereby authorize Drs. Cohen, Tattelbaum, Yang and Watkins of the Washington Plastic Surgery Group, L.L.C. to bill my insurance Company for service of rendered to me and/or my family. I understand that these payments are made directly to the doctor. I understand that this in no way relieves me of my primary responsibility to pay for services to me (or my minor child). I understand and agree that interest of 1.5% per month (18% annum) will be added as a late charge for any account not paid within 30 days of when the balance is due. If my account is referred to an attorney for collections I agree to pay any reasonable legal fees (25% is deemed reasonable), court costs, and other collection expenses. I certify that the information provided about my Insurance Company is correct I authorize the release of medical information requested by my Insurance Company. A copy of this form can be sent to my Insurance Company in lieu of a signature when necessary. I am responsible for the balance after the insurance payment.

______________________________ ______________________________ __________
SIGNATURE of Responsible Party **PRINT** Responsible Party Name Here Date