CHANGES PLASTIC SURGERY
PATIENT INFORMATION

Mr. / Mrs. / Ms. / Miss Nickname ______________________
NAME (last, first, MI):____
Address:__________________________ Unit # ______ City & State:____________ Zip: ______________
Home Phone#: (____)____________________ Work Phone#: (____)____________________ ext ____________
Cell Phone # (_____) ________________ E-Mail ______________________ May we contact you: ☐ Y or N ☐
Date of Birth:_____/_____/_________ Age: _______ Sex: Male ☐ / Female ☐ SS#:______________________

PATIENT EMPLOYMENT INFORMATION:
Occupation:______________________________ Employer:______________________________
Address:________________________ City:________________CA: _____ Phone#: (____)______________

HOW DID YOU FIND US? Google/ RealSelf / Facebook / Yelp / San Diego Magazine / Other Internet __________
(please circle one) (source name)
REFERRED BY:____ Phone#: (____)______________________

RESPONSIBLE PARTY'S NAME:____________________________ Phone: (____)______________________
(If not the patient)

PRIMARY INSURANCE:
Insurance Carrier:________________________________ Address:______________________________
City, State & Zip:________________________________ Phone#:(____)__________________________
Policy ID#:______________________________________ Group#:______________________________
Subscriber Name:_________________________________ Relationship: Self _____ Spouse:____ other:_______

SECONDARY INSURANCE:
Insurance Carrier:________________________________ Address:______________________________
City, State & Zip:________________________________ Phone#:(____)__________________________
Policy ID#:______________________________________ Group#:______________________________
Subscriber Name:_________________________________ Relationship: Self _____ Spouse: _____ Other: ____

MARITAL STATUS : SINGLE MARRIED DIVORCED SEPARATED WIDOWED

SPOUSE:
Name:__________________________________ SS#:____________________ Date of Birth:______________
Home Phone#: (____)_________________ Work #: (____)___________________Cell # (____) ______________

EMERGENCY INFORMATION (a relative or friend not living with you):

Name:____ Relationship:____________________________
Address:__________________________________ City & State:____________________ Zip:______________
Phone#: (____)______________________________ Cell Phone # (_____)__________________________

I hereby irrevocably assign and transfer all payment of benefits for the services rendered by Changes Plastic Surgery & Spa to be made directly to him regardless of my insurance benefits, if any, and agree to allow a photocopy of my signature to be used to file insurance. I understand that each patient (or responsible party) is financially responsible for services rendered. While the Business Office is pleased to assist in the preparation and submission of insurance forms, the obligation for payment remains that of the responsible party. In the case of an accepted Worker's Compensation injury, it is understood that the patient is not financially responsible. I also authorize Gilbert W. Lee, M.D. to render medical treatment.

______________________________ ______________________________
PATIENT SIGNATURE RESPONSIBLE PARTY SIGNATURE

______________________________ ______________________________
DATE DATE