Christiana Cosmetic Surgery Consultants
Jonathan Saunders, MD – Katheryn Warren, MD – Julia MacRae, MD

E-62 Omega Dr
Newark, DE 19713
(302) 368-9611

STRICTLY CONFIDENTIAL PATIENT INFORMATION

PLEASE PRINT CLEARLY

DATE ___________________

NAME ____AGE_____ BIRTH DATE ______________ SS# _________________

ADDRESS ____ E-MAIL ___________________________________

CITY _________________________________ STATE _______ ZIP CODE ________________**PREFERRED NAME**:______________________

PRIMARY PHONE_____________________CELL PHONE_______________________WORK PHONE ___________________

MARITAL STATUS: S M W D SEP [ ] MALE [ ] FEMALE [ ] TRANS/NON-BINARY [ ] PRONOUN_________________

EMPLOYMENT STATUS: [ ] FULL TIME [ ] PART TIME [ ] RETIRED [ ] UNEMPLOYED

ARE YOU A STUDENT? [ ] FULL TIME [ ] PART TIME [ ] NOT A STUDENT

YOUR EMPLOYER: ____ WORK PHONE NUMBER:_______________

SPOUSE OR PARENT'S NAME: ___________________________ SS# __________________ BIRTH DATE _______________

SPOUSE OR PARENT'S EMPLOYER ____WORK PHONE ___________________

PRIMARY CARE PHYSICIAN (PCP)____ PHONE _________________________

PHARMACY NAME, ADDRESS & PHONE____

____

PERSON TO CONTACT IN CASE OF EMERGENCY _________________________________ PHONE ___________________

PERSON RESPONSIBLE FOR PAYMENT **(if not above)** ____

ADDRESS ____ PHONE ________________________

YOU MUST COMPLETE THE FOLLOWING STATEMENT

I authorize release of my protected healthcare information to: ____

Relationship:________________________________ **Telephone number:** ________________________________

Can appointment reminders be left on your home answering machine? _____Yes _____No

Can messages asking you to call the office concerning healthcare information be left on answering machine? ____Yes ____No

INSURANCE INFORMATION

PRIMARY (1ST) INSURANCE

NAME OF INSURANCE COMPANY ____ PHONE _____________________

SUBSCRIBERS NAME ____ BIRTH DATE ____________________

ID or POLICY # ______________________________________ GROUP # __________________________ PLAN # __________

RELATIONSHIP TO INSURED: [ ] SELF [ ] SPOUSE [ ] CHILD [ ] OTHER___________________________________

SECONDARY (2ND) INSURANCE

NAME OF INSURANCE COMPANY ____ PHONE _____________________

SUBSCRIBERS NAME ____ BIRTH DATE _____________________

ID or POLICY # ______________________________________ GROUP # __________________________ PLAN # __________

RELATIONSHIP TO INSURED: [ ] SELF [ ] SPOUSE [ ] CHILD [ ] OTHER ___________________________________

*YOU ARE FINANCIALLY RESPONSIBLE FOR ALL CO-PAYS AND FEES REGARDLESS OF INSURANCE COVERAGE. *

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that any authorized Medicare or other insurance company payments be made for me on my behalf to Jonathan Saunders MD, Katheryn Warren MD and Julia MacRae MD for any services rendered to me by that party that accepts assignment. Regulations' pertaining to Medicare assignment of benefits does apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or a related Medicare or other insurance company claim.

I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the CMS-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare or other insurance company assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare or other insurance company as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare or other insurance company.

Signature____ Date________________________________

PLEASE REVIEW AND SIGN OUR FINANCIAL

[ ] I have received a copy of this office's Privacy Statement under HIPPA guidelines