

CHARLES A. WALLACE, M.D., F.A.C.S.

Plastic and Reconstructive Surgery

PATIENT INFORMATION

Please Print

Name: _____ Home Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Birthday: _____ Age: _____ Sex: _____ Marital Status: _____

Social Security #: _____ Driver's License #: _____

Email: _____ Cell Phone: _____

Employer: _____

Business Address: _____

Occupation: _____ Work Phone: _____

Nearest Relative Not Living With You: _____

_____ Phone: _____

Whom May We Contact In An Emergency? _____

_____ Phone: _____

Whom May We Thank For Referring You To Us? _____

_____ Phone: _____

Who Is Responsible For Your Bill? _____

Today I Will Be Paying By: Cash _____ Check _____ Credit Card _____

MEDICAL INSURANCE

Primary Insurance Co. Name: _____

Address: _____

ID #: _____ Group #: _____

Insured: _____ Phone #: _____

Secondary Insurance Co. Name: _____

Address: _____

ID #: _____ Group #: _____

Insured: _____ Phone #: _____

ASSIGNMENT OF INSURANCE BENEFITS & CONSENT TO PAY

The Undersigned hereby authorizes and consents to be seen and treated by Dr. Charles Wallace, in addition to the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered and for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the Undersigned had personally signed the particular claim. I also authorize payment on my claim, if any, to be made directly to Charles A. Wallace, M.D.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have completed the above questions and I certify this information is **TRUE** and **CORRECT** to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature _____ Date _____

Parent (if minor) _____ Date _____

MEDICAL INFORMATION

Name of Patient: _____

Reason For Consultation: _____

Age: _____ Height: _____ Weight: _____ Blood Type: _____

Serious Illnesses: (Past/Present): _____

(Include Dates) _____

Previous Surgeries: (Dates/Procedure/Physician) _____

Serious Injuries/Accidents: (Date/Physician) _____

Please List All Medications, Prescription and Non-Prescription, you are currently taking or take on a routine basis: _____

Do You Take ASPIRIN? No _____ Yes _____ (How Often?) _____

MEDICATION ALLERGIES

Codeine _____ Sulfa _____ Morphine _____ Penicillin _____ Mycins _____ Tetracycline _____

Others _____

Are You Allergic To Any Topical Preparations? _____

Tape _____ Betadine _____ Others: _____

Hereditary Disorders (e.g. Bleeder, Diabetes, Cancer, Hypertension, Heart Disease, etc.) _____

Do You Smoke? No _____ Yes _____ If Yes, How Long and How Much? _____

Do You Drink? No _____ Yes _____ If Yes, How Often and How Much? _____

Family Physician: _____ Phone: _____

Pharmacy: _____ Phone: _____

REV 8/08

