# NEW HORIZONS PLASTIC SURGERY

936-564-3744

Patient Information as of _____ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

**Patient's Name** _____
First Middle Last

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Driver's License # _____

Race _____ Ethnicity _____ Language _____

Any restrictions for contacting you? ❒ No ❒ Yes E-mail _____

**Best way to reach you?** _____

Age _____ Birthdate _____ SS# _____ Gender ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: _____ ❒ Other: _____

**Patient's Employer** _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
Street & Suite # City State Zip

**How did you hear about Dr. Wittpenn?** (Mark all that apply)

❒ TV News ❒ TV Ad ❒ Phone Book ❒ Magazine ❒ Newsletter ❒ Seminar ❒ Salon ❒ Web

❒ Friend/Relative: _____ ❒ Doctor: _____ ❒ Other: _____

*** My medical information may be discussed with the following family/friends per HIPAA regulations:** _____

**Emergency Contact**
(Not in your household) _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

**Primary Health Insurance Company** _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ _____

**Insured**: Name _____ DOB _____ Employer _____

**Secondary Health Insurance Company** _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ _____

**Insured**: Name _____ DOB _____ Employer _____

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Wittpenn to bill my insurance company for medically necessary services. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Wittpenn and myself.

**Signature** _____ **Date** _____