



Chart #: _____

35080 U.S. Highway 19 North · Palm Harbor, FL 34684
At the Fountains
(727) 789-5711 · Fax: (727) 789-4098
www.plasticsurgerycentre.com

Plastic Surgery Centre

EREL LAUFER, M.D., F.A.C.S.

JAY H. ROSS, M.D., F.A.C.S.

Last Name: _____ First Name: _____ Middle Initial _____ Date of Birth _____ Age: _____ Sex: _____

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

Cell #: _____ OK To Call: Yes No E-mail address: _____ @ _____

Home #: _____ Employer: _____ Work #: _____

Social Security Number: _____ - _____ - _____ Driver's License #: _____ Marital Status: _____

Spouse or Parent's Name: _____ Phone #: _____

Person to Contact in Case of
Emergency: _____ Phone #: _____

How did you hear about us? Doctor Friend _____ Patient Internet Newspaper Sign TV YellowPages
Name: (Optional) Other _____ CHECK ALL THAT APPLY

Family Doctor: _____ Phone #: _____

RESPONSIBLE PARTY NAME (If other than yourself)

Last Name: _____ First Name: _____ Middle Initial: _____

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

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

Employer: _____ Occupation: _____ Home #: _____

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

MEDICAL INSURANCE INFO: MEDICARE #: _____ SUPPLEMENTAL INSURANCE: _____

HMO, PPO, PRIVATE INS.: _____

POLICY #: _____ GROUP #: _____

INSURED NAME: _____ DATE OF BIRTH: _____ SOCIAL SEC. #: _____

Were you involved in an accident? _____ Work Related? _____

State Briefly What Happened: _____

Date of Accident: _____ Verified: _____ Date: _____

Please remember that insurance is considered a method of reimbursing the patient fees to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL YOUR COST OF BILLING WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to: Palm Harbor Plastic Surgery Centre (Erel Laufer, M.D., F.A.C.S. or Jay H. Ross, M.D., F.A.C.S.) This assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of the patient's record.

SIGNED _____ DATE _____