



PATIENT INFORMATION

Patient LEGAL Name _____
Last First M.I.

Mailing Address _____
Street Apt./Unit# City State Zip

Home Phone (____) _____ Male Female

Cell Phone (____) _____

Marital Status _____ Birthdate _____ Age _____ SS# _____ - _____ - _____

Employer _____ Occupation _____ Employer Phone (____) _____

Full Time Part Time Medical Leave Unemployed Student Retired Other

Employer Address _____

GUARANTOR INFORMATION - Person Responsible for the Bill (If same as patient, only check "Self" and do not complete this section).

Patient's Relationship to Guarantor: Self Spouse Child Legal Guardian Other

Guarantor's Name _____ SS# _____ - _____ - _____ Phone (____) _____

Home Address _____

Street Apt./Unit# City State Zip

Birthdate _____ Employer Name _____ Phone (____) _____

Occupation _____ Employment Status Full Time Part Time Retired Other

NEAREST RELATIVE OR CLOSE FRIEND

Name _____ Address _____

Relationship _____ Home Phone (____) _____ Work Phone (____) _____

OTHER INFORMATION

Primary Care Physician _____ Phone (____) _____

Address _____

Referring Physician _____ Phone (____) _____

Address _____

We are very interested in knowing how you first learned about our services. Please indicate where you heard or read about us by checking off all sources of information that apply. Thank you so much for your help.

Your physician A Friend ER Yellow Pages Internet Denver Post

Westword Rocky Mountain News The Villager TV Radio

Other, please specify _____

Would you like to be on our email directory? Yes No

E-mail address _____

ASSIGNMENTS OF BENEFITS

Release of Medical Information

I hereby authorize the release of medical information necessary to process insurance claim forms.

Date _____ X _____

Assignment of Benefits

I hereby authorize payment of surgical and medical benefits to John Fox Bershof, M.D.

I understand that I am financially responsible for all charges incurred, whether or not covered by insurance.

Date _____ X _____

PHOTOGRAPHS

Permission is hereby given for photography. It is the tradition of Plastic Surgery to document therapy with before and after photographs, and, with intra-operative photographs. These photographs become an integral and permanent part of the medical record. Please be assured that any photographs are held in strictest confidence. I give permission for my photograph to be used for patient education, lectures, medical research, education, or science so long as it is done anonymously. Commercial use of my photographs will not occur without my express written consent.

I have read the foregoing, and understand.

Date _____ X _____

X _____