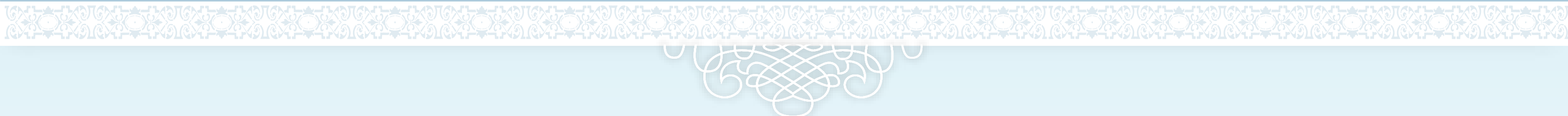
RECONSTRUCTIVE & AESTHETIC SURGERY



Date: ______________________

Name: ______________________ DOB: ____________ Age: ____________

Address: ______________________ Home Phone: ______________________

Work Phone: ______________________

City: ____________ Zip Code: ____________ Cell Phone: ______________________

Social Security #: ______________________ Employer: ______________________

Work Address: ______________________

Primary Care Physician: ______________________ Referred By: ______________________
Address: ______________________
Phone: ______________________
Primary Insurance: ______________________ Secondary Insurance: ______________________
Policy #: ______________________ Policy #: ______________________
Subscriber's Name: ______________________
Subscriber's DOB: ______________________

If this is not a Workers' Compensation Injury or Motor Vehicle Accident, please skip to the office policy section below.

Workers' Compensation Injury

Date of Injury: ______________________ Employer at time of injury: ______________________
Case #: ______________________ Case Manager: ______________________
Carrier: ______________________ Carrier Address: ______________________

Motor Vehicle Accident

Responsible Insurance Company: ______________________ Address: ______________________
Policy Holder: ______________________ Policy Number: ______________________

Policies

- I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance; including cost of collections and attorney fees. I also authorize Stephen M. Evangelisti, M.D. or insurance company to release any information required for processing of medical claims.
- If surgery is scheduled at a surgery center; a three-week notice prior to the surgery date is needed. Otherwise, a cancellation fee of $500.00 will be incurred by the patient.
- A $25.00 returned check fee will be applied to your account for any checks returned for non-payment.
- We request 48-hours notice for appointment cancellations. A cancellation fee of $50.00 will be applied to your account if this notice is not received.
- A chaperone will be present in all medical exams, unless declined by patient.
  Signature, if declined: ______________________

Patient/Guardian Signature: ______________________ Date: ____________

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