Plastic Surgery
Surgery of the Breast

Cosmetic Surgery
Surgery of the Hand

STEPHEN M. EVANGELISTI, M.D.

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585-325-1120

Date:_____

Name:_____ DOB:_____ Age:_____

Address:_____ Home Phone:_____

_____ Work Phone:_____

City_____Zip Code_____ Cell Phone:_____

Pharmacy Name: _____ Email Address:_____
Pharmacy Address:_____ Pharmacy Phone:_____
_____ _____

Primary Care Physician:_____ Employer:_____
Address:_____
Phone:_____ Referred By:_____

Primary Insurance:_____ Secondary Insurance:_____
Subscriber's ID #:_____ Subscriber's ID #:_____
Subscriber's Name:_____ Subscriber's Name: _____
Subscriber's DOB:_____ Subscriber's DOB: _____

If this is a Workers' Compensation Injury or Motor Vehicle Accident, please complete this section.

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 cosmetic surgery is scheduled at a surgery center; a 30 day cancellation notice prior to the surgery date is needed. Otherwise, a cancellation fee of $500.00 will be incurred by the patient. If patient cancels or reschedules, for non- medical reason seven (7) days or less prior to the scheduled surgery date, 50% of the total surgeon fee will be non-refundable.
- 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.
- I hereby authorize Dr.Evangelisti, and his medical staff/employees, to take photographs/digital images/videotapes of myself in whole or in part for establishing a treatment plan, evaluating surgical outcomes, pre-authorization for surgery, educational purposes, and to show prospective patients before and after results from surgery. When used in this fashion, these photographs/digital images/videotape are not labeled with patient identification and any identifying features (except facial photos) will be edited or removed.
- I would like to receive text message appointment reminders ____ Yes ____No
- I would like to receive e-mail appointment reminders ____ Yes _____ No

Signature:_____ Date:_____

Revised 6/16/22