FACIAL PLASTIC SURGERY OF BEAUMONT
Welcome to Our Office

Today's Date _____ Referral Source _____

Patient's Name (Last) _____ (First) _____ (MI) _____ □ Male □ Female

Address _____ City _____ State _____ Zip _____

Telephone (____) _____ Cell (____) _____ Birthdate _____ Age _____ Marital Status ____

Social Security # _____ Occupation _____

Employer _____ Telephone # (_____) _____

Employer Address _____ City _____ State _____ Zip _____

Emergency Contact not living with you _____ Relationship _____

Contact's Home Phone (_____) _____ Contact's Alternate Phone(____) _____

Email Address _____ Spouse's Name, if applicable _____

If patient insurance coverage is provided through someone else, please complete:
If patient under 18, provide BOTH Mother and Father or Guardian information:

Insured Name(OR Mother) _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Telephone (____) _____ Birthdate _____ Age _____ Social Sec # _____

Employer _____ Telephone # (_____) _____

Employer Address _____ City _____ State _____ Zip _____

Insured Name(OR Father) _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Telephone (____) _____ Birthdate _____ Age _____ Social Sec # _____

Employer _____ Telephone # (_____) _____

Employer Address _____ City _____ State _____ Zip _____

1st Insurance Company _____ Address _____

Policy Holder _____ Birthdate _____ Relationship to patient _____

Policy #_____ Group # _____

2nd Insurance Company _____ Address _____

Policy Holder _____ Birthdate _____ Relationship to patient _____

Policy #_____ Group # _____

I authorize the release of any medical information necessary to process this claim or provide continued medical care to a referring doctor/facility. I authorize payment of medical and surgical benefits to Southeast Texas Ear, Nose and Throat, LLP. I agree to be responsible for any payment not paid by my insurance due to lack of referral, deductible, co-insurance, etc. I consent to all services, treatment, and diagnostic procedures as ordered by my physician. I will notify the office of any insurance changes prior to treatment or surgery.

_____ _____
Signature of Patient/Responsible Party Date