# MCCUE PLASTIC SURGERY, P.A.
# PATIENT'S DEMOGRAPHIC SHEET

**PATIENT INFORMATION** **Date** _____

**Patient Name**_____**Date of Birth**_____

Address_____City_____ State_____ Zip_____

Home Telephone_____ Work Telephone_____ Cell Phone: _____

Soc Sec #_____ Email _____ Sex: □ Male □ Female

Check appropriate box: □ Minor □ Single □ Married □ Divorced □ Widowed □ Separated

Patient's employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Spouse or parent's name _____ Employer _____

Address_____ City_____ State_____ Zip_____

Whom may we thank for referring you? _____ Purpose of today's visit _____

Primary Care Physician _____ Clinic Name: _____ Address: _____

→ would you like a referral letter sent? Y N

Pharmacy _____ Telephone: _____

Person to contact in case of emergency _____ Relationship to patient _____Telephone _____

Address_____ City_____ State_____ Zip_____

**RESPONSIBLE PARTY**

Name of person responsible for this account _____ Birth Date _____

Relationship to patient _____ Employer _____

Address _____City _____ State _____ Zip _____

Home Phone_____ Work Phone _____Cell Phone_____

**INSURANCE INFORMATION**

Worker's Compensation **Y N** Auto-Related **Y N** Date of Injury/Onset:_____

**Primary Insurance Carrier** _____

Policyholder's Name:_____Relationship to patient_____

Policy #/Group #_____ ID#_____

Ins. Co. address _____ City _____State _____ Zip_____

**Secondary Insurance Carrier** _____

Policyholder's Name:_____Relationship to patient_____

Policy #/Group #_____ ID#_____

Ins. Co. address _____ City _____State _____ Zip_____

**RELEASE AND ASSIGNMENT:**

I hereby authorize McCue Plastic Surgery, P.A. to release to my insurance carrier or its designated representatives, as well as to any physician/organization who participates in my treatment for related diagnosis, any information including the diagnosis and records of my treatment rendered to me during the period of such medical and/or surgical care. I further consent to the photographing of myself and/or minor child for teaching and medical records for services provided. I fully understand that I am responsible for all charges incurred, regardless of insurance coverage. I also understand that if my account is considered past due, a finance charge of 1.5% per month (18 % annually) will be assessed

**Patient's Signature**_____ **Guarantor's Signature**_____