



Reason For Consultation _____

Patient's Name: _____
Last First Middle

Address: _____
Street Apt # City State Zip

Home Phone: _____ Cell Phone: _____

E-mail Address: _____ Work Phone: _____

May we contact you via email or mail for special promotions and seminars? Yes No
Any Restrictions for contacting you? Yes No If yes, please explain: _____
How would you like us to confirm your appointments? Cell Phone Home Phone Work Phone

How did you find out about us? Referring Doctor _____
 Current Patient _____ May we thank the current patient that referred you? Yes No

On The Following Please Check All That Applies

- Newspaper: Quad City Times Dispatch/Argus/The Leader
- Web Site/Search Engine: www.iowaplasticsurgery.com Google Yahoo MSN Ask
- Yellow Pages: Qwest Dex SBC/RH Donnelley Yellow Book
- Iowa Plastic Surgery: Employee Seminar Handout/Flyer Television

Male: _____ Female: _____ Birth date: _____ Age: _____ S.S#: _____

Single: _____ Married: _____ Other: _____ Spouses Name: _____

Employer _____ Occupation _____

Emergency Contact (not in your household) _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Cell Phone _____

If Minor: Name of responsible party _____ Relationship _____

Address (If the same write same) _____

Phone Number _____ SS# _____

Primary Health Insurance Company: Please provide insurance card for receptionist

I understand that office visit charges are payable on the day service is rendered. I authorize Iowa Plastic Surgery to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Iowa Plastic Surgery and myself. I also understand if my insurance requires a referral, second opinion, or pre-authorization, I am responsible to inform my physician of these provisions. Failure to do so may result in my insurance carrier denying my claim, and I will be responsible for any balance resulting if this occurs.

Many procedures require photographs: I consent to be photographed and photographs will remain the property of Iowa Plastic Surgery. I give permission for these to be used for insurance payment and approval if applicable. If I give permission, these may be used for educational and demonstrated purposes including publication, and I will not be identified by name.

Signature _____ Date _____

Receipt Of Notice Of Privacy Practices1,** _____ have received a copy of Iowa Plastic Surgery's Notice of Privacy Practice 12/5/2005.