



NORTHSHORE
PLASTIC SURGERY

Benjamin J. Boudreaux, M.D.

Patient Information

Today's Date: _____

Name: _____

Last

First

MI

Mr. Mrs. Ms. Dr.

I prefer to be called: _____ Male Female

Birthdate: ___/___/___ Age: ___ Social Security #: _____ Single Married Divorced

Widowed Separated

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: () _____

Occupation: _____ Employer: _____

Years There: _____ Employer's Address: _____

City: _____ State: _____ Zip: _____

Work Phone: () _____ Cell Phone: () _____

E-mail: _____

Emergency Contact

His/Her Name: _____ Relation: _____

Work Phone #: _____ Home Phone #: _____

Address: _____

Street/P.O. Box

City

State

Zip

Complete this section only if someone other than the patient is financially responsible.

Responsible Party: _____ Relationship to Patient: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone: () _____ Birthdate: _____ Age: _____

Occupation: _____ SSN: _____

Employer: _____ Years There: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Work Phone: () _____

Spouse Information:

Name of Spouse: _____ Birthdate: _____ Age: _____

Occupation: _____ SSN: _____

Employer: _____ Years There: _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Employer's Telephone: () _____

In case of emergency, contact: _____ Relationship: _____

Home Phone: () _____ Work Phone: () _____

Patient Name _____

Chart # _____

Patient Information cont.

How did you learn about Dr. Boudreaux? _____

Can we mail information to your home? Yes No

Can we leave a message for you at home? Yes No

Can we leave a message for you at work? Yes No

Can we send e-mail to the address you provided? Yes No

Insurance Information

Company (Name, Address): _____ Policy Holder Name: _____

Group#: _____ Policy#: _____ Policy Holder Birthdate: _____

Company (Name, Address): _____ Policy Holder Name: _____

Group#: _____ Policy#: _____ Policy Holder Birthdate: _____

Is this the result of an accident or injury? Yes No Explain: _____

Work-Related? Yes No Date of Injury? _____ Auto-Related? Yes No Date of Accident: _____

Did you report the accident to your employer? Yes No

Workers Comp Information _____ Case Worker _____

Is there an attorney involved? Yes No If yes, please notify the receptionist.

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts. See our complete financial policy for details.

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Benjamin J. Boudreaux, M.D., to release information requested by my insurance company or workmen’s compensation carrier. I also authorize Benjamin J. Boudreaux, M.D., to release information to any hospital or physician to which I may be referred by this office. In addition I authorize Benjamin J. Boudreaux, M.D., to request and obtain my medical records from my insurance company, workmen’s compensation carrier, hospitals, and/or physicians who have treated me. I hereby authorize assignment and payment directly to Northshore Plastic Surgery, LLC, from major medical benefits or legal settlements and/or judgments due me. I hereby agree to pay any and all charges that exceed or that are not covered by insurance. I understand I will be responsible for any fees attached to this account in order to recover any uncollected balances.

Signature _____ Date: _____

Relationship to patient _____