

# SUFFOLK PLASTIC SURGEONS, P.C.

Is this a **Work Related Injury**? Yes  / No  Is this a **Motor Vehicle Injury**? Yes  / No   
IF YOU ANSWERED YES TO EITHER QUESTION, PLEASE INFORM THE FRONT DESK.  
**ADDITIONAL FORMS MAY BE REQUIRED**

Patient: \_\_\_\_\_  
FIRST MIDDLE LAST

Street Address: \_\_\_\_\_  
STREET & APT. # CITY STATE ZIP CODE

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mailing Address(if different) : \_\_\_\_\_ Email Address: \_\_\_\_\_

Sex: Female  Male  Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_

Marital Status: Single  Married  Divorced  Widowed  Other

Name of Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Student: Full Time  Part Time  Where? \_\_\_\_\_

Who May We Thank For Referring You? \_\_\_\_\_

Did You Seek Treatment at the Emergency Room For This Injury/Illness? Yes  No  If YES, Date: \_\_\_\_\_ Hospital Name: \_\_\_\_\_

Are you interested in a **Complimentary Consultation** at our Medical Spa? Yes  No   
Come and visit **Spa Belle Meade, The Medical Spa** located in **Suite 2**  
to learn about the procedures we offer.

**Due to HIPAA Law we are not allowed to disclose any medical information without written authorization.**

1) Can we **send mail** to the address listed above (other than for billing purposes) YES  NO

2) Do we have your permission to leave a message (with anything more than an appointment reminder) on a answering machine at **Home**? YES  NO  **Cell Phone**? YES  NO  at your **Place of Employment**? YES  NO

3) Do we have your permission to discuss your medical condition with any member of your household? YES  NO   
If YES, whom: \_\_\_\_\_ Relation: \_\_\_\_\_

This **Does NOT** give authorization for anyone to receive your written medical records.  
Patients must sign a records release form to receive copies of records.

I hereby authorize any physician, healthcare practitioner, hospital, medical related facility, insurance company or consumer reporting agency to furnish any and all records, photographs, medical history, services rendered or treatment given to myself or any dependent for the purpose of review, investigation or evaluation of any claim submitted to insurer.

If there is a default in the payment of any sums due, I agree that I will additionally pay reasonable attorney's fees, collection and court costs, including a fee equal to 35% of the outstanding debt. I request that payment of the authorized insurance benefits be paid on my behalf directly to Hilton C. Adler, MD, Stephen F. Coccaro, MD or Kenneth C. Kneessy, MD, for all services rendered by this office.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

**Patient**

FIRST NAME

MIDDLE NAME

LAST NAME

**Primary Health Ins.  
Name & Address**

Identification # \_\_\_\_\_ Group # \_\_\_\_\_ Effective Date : \_\_\_\_\_

Policy Holder: \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

Policy Holder's Address  
(if Different from Patient) \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_ Policy Holder's  
Relation to Patient \_\_\_\_\_

Does This Plan  
Require a Referral? Yes  / No  Co-payment: \$ \_\_\_\_\_ **(For HIP or Vytra Plans Only)**

**Secondary Health Ins.  
Name & Address**

Identification # \_\_\_\_\_ Group # \_\_\_\_\_ Effective Date: \_\_\_\_\_

Policy  
Holder: \_\_\_\_\_ DOB \_\_\_\_\_ SS# \_\_\_\_\_

Policy Holder's Address  
(if Different from Patient) \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_ Policy Holder's  
Relation to Patient \_\_\_\_\_

Does This Plan  
Require a Referral? Yes  / No  Co-payment: \$ \_\_\_\_\_ **(For HIP or Vytra Plans Only)**

**\*\*OTHER LIABILITY\*\***

**Did this injury involve:**

**School/College/  
Sports League**

Yes  / No

If **Yes**, was a claim filed: Yes  / No

Date of  
Injury

Name of  
School or  
League

\*\*\*If a claim was **not filed**, you must **contact the school/league** to file a claim and **obtain a claim form.** \*\*\*

\*\*\*This **MAY** help to defer any financial liability you may have \*\*\*\*

**Did this injury occur at a Place of  
Residence OTHER than your own**

Yes  / No

If **Yes**, was a claim filed: Yes  / No

Ins. Co. Name  
& Address

Date of  
Injury

\*\*\*If a claim was **not filed**, you must **contact the Homeowner** to file a claim. \*\*\*

This **MAY** help to defer any financial liability you may have \*\*\*\*

**Have you Obtained an  
Attorney for this Injury/Illness**

Yes  / No

Attorney's  
Name:

Attorney's  
Address

Phone#

**\*\*\*PLEASE SEE THE FRONT DESK FOR ADDITIONAL FORMS IF MOTOR VEHICLE OR WORK RELATED \*\*\***

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship: \_\_\_\_\_