Ambulatory Surgical
Surgicenter
PHILIP C. KEENEY, M.D.
BOARD CERTIFIED PLASTIC SURGEON
C.J. LYNN CHUNG, M.D.
BOARD CERTIFIED PLASTIC SURGEON

PATIENT INFORMATION

Today's Date: _____

Patient Name _____ Birthdate _____ Age _____
Last *First* *Middle*

Home Address _____ Phone (___) _____

City _____ State _____ Zip _____ Email _____

May we send you promotions via email or text? YES NO

Address to receive mail from our office _____ Patient Sex: Male Female

Marital Status: S M Sep Div Wid Spouse _____ Spouse Phone (___) _____

Patient Social Security #_____ Patient Employer _____ Occupation _____

Employer Address _____ Work Phone (___) _____

Referred to our office by _____Phone (___) _____

MEDICAL INFORMATION

Family Physician _____ Phone (___) _____Pharmacy _____ Phone (___) _____

Are you presently under another's doctor's care? _____

Have you seen another doctor for this procedure? _____

Have you ever consulted a doctor for:

Heart _____ Blood Pressure _____ Medication Allergies _____

Lungs _____ Bleeding Disorders/ Blood clots _____ Other _____

Please list medications you are currently taking: _____

_____

INSURANCE INFORMATION *(Complete ONLY if not an elective cosmetic procedure.)*

Company _____ Subscriber's Name _____

Co-Pay $_____ Deductible $_____ Subscriber's DOB _____

Subscriber's SS# _____ Group # _____

Subscriber's Employer _____ Medicare # _____

ADDITIONAL INSURANCE

Company _____ Subscriber's Name _____

Subscriber's SS#_____ Group # _____

EMERGENCY CONTACT INFORMATION *(Emergency Contact/Relative not residing in the same household.)*

Emergency Contact _____ Phone (_____) _____

Nearest Relative _____ Phone (_____) _____

RESPONSIBILITY

I have completed this form completely, and certify that I am the patient or duty-authorized general agent of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for the payment of services.

X_____ (Signature of Patient, Parent or Responsible Party)

I authorize the release of medical records information to my insurance company undercuts that payments be made directly to the attending physician.

X_____ (Signature of Patient or Authorized Party)

NOTICE

We keep a record of the healthcare services we provide you. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or complies us to do so.

X_____

(Signature of Patient, Parent or Responsible Party)

Authorization for Release of Medical Information

I hereby authorize Drs. Kierney and/or Chung to release any or all medical records to those individuals for who it is necessary to receive such information, either for the purposes of medical treatment, peer review, or medical quality assurance.

Name: _____

Signature: _____

Date: _____