North Dallas Plastic Surgery Associates

Harlan Pollock, M.D. *Todd Pollock, M.D.*

PATIENT INFORMATION

Today's Date: _____ **E-mail Address**_____

Would you like to receive information via our website? Y____ N____

☐ **HIPAA** **Referred By**_____

Patient's Name: _____ _____
First Name MI Last Name Marital Status

Address: _____ _____ _____ _____ _____
Street Apt# City State Zip

Home #: (____)_____ **Cell #**: (____)_____ **Work #**: (____)_____ ext

SS#: _____-_____-_____ **Sex**: ☐ **Female** ☐ **Male** **DOB**: _____/_____/_____ **Age**: _____

Employer: _____ **Occupation**: _____

Address: _____ _____ _____ _____ _____
Street Apt # City State Zip

If Applicable: Spouse's Name: _____ **SS#**: _____-_____-_____

DOB: _____/_____/_____ **Employer**: _____ **Work #**: (____)_____

Responsible Party: _____ Relationship: ___Self ___Spouse ___ Parent ___Other: _____

If case of an emergency, contact: Name: _____

Phone #: (____)_____ **Relationship to patient**: _____

COMPLETE IF PATIENT IS UNDER 18 YEARS OF AGE

Father's Name: _____ **Employer**: _____

Work #: (____)_____ **DOB**: _____/_____/_____ **SS #**: _____-_____-_____

Mother's Name: _____ **Employer**: _____

Work #: (____)_____ **DOB**: _____/_____/_____ **SS #**: _____-_____-_____

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING AND COMPLETE THE REQUESTED INFORMATION

Insurance Co. # 1: _____ **Primary Ins. Holder Name**: _____

Phone #: (____)_____ **DOB**: ____/____/____ **SS #**: _____-_____-_____ **Relationship**: _____

Insurance Co. # 2: _____ **Primary Ins. Holder Name**: _____

Phone #: (____)_____ **DOB**: ____/____/____ **SS #**: _____-_____-_____ **Relationship**: _____

********Payment is due at the time of service. Cosmetic procedures are prepaid. If you have insurance benefits for a procedure, co-payment and deductible will be collected. Insurance claims will be filed on behalf of the patient for these insurance benefits.*******

RELEASE OF MEDICAL INFORMATION & ASSIGNMENT OF BENEFITS

I hereby authorize NDPSA to release any medical information necessary to complete and process my insurance claims. I also authorize the payment of medical benefits to NDPSA for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.

X_____ Date: _____
Patient's OR Insured's Signature (If patient is a Minor, must have Responsible Party Signature)

I authorize Dr. Harlan Pollock and Dr. Todd Pollock to treat me and use my personal health information for healthcare operations.

X_____ Date: _____
Patient's Signature (OR Parent if patient is a minor)