John M. Rowley, M.D.
Palo Verde Plastic Surgery

Palo Verde Plastic Surgery
4545 E Chandler Blvd, Suite 110 ; Phoenix ,AZ 85048
Phone: 480-759-3001 • Fax: 480-759-1341

PATIENT DEMOGRAPHICS

PLEASE FILL OUT COMPLETLEY AND PRINT CLEARLY

FULL LEGAL NAME: _____ **DOB (MM/DD/YYYY):** _____

AGE:_____ **GENDER:** ☐ Female ☐ Male **SOCIAL SECURITY NUMBER:** _____

MARITAL STATUS: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

MAILING ADDRESS: _____ **Apt/Suite:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

☐ **HOME PHONE:** _____ ☐ **CELL PHONE:** _____

☐ I agree to allow Palo Verde Plastic Surgery to leave a detailed messages /test results on my voicemail at the above number(s) (Please check at least one phone number above)

☐ I do NOT wish for Palo Verde Plastic Surgery to leave a detailed messages/test results on my voicemail.

EMAIL ADDRESS: _____

PREFERRED PHARMACY: (Name, location, and cross streets): _____

EMPLOYER : _____ **EMPLOYER** PHONE: _____

EMERGENCY CONTACT INFROMATION

EMERGENCY CONTACT:_____ **PHONE NUMBER:** _____

RELATIONSHIP TO PATIENT _____ **PERMISION TO LEAVE MESSAGE** ☐ YES ☐ NO

PHYSICIAN & REFERRAL INFORMATION

PRIMARY CARE PHYSICIAN(PCP):_____ **PHONE NUMBER:** _____

REFERRING PHYSICIAN: _____ **PHONE NUMBER:** _____

HOW DID YOU HEAR ABOUT US? (please provide name or platform) ☐ Insurance_____

☐ Family Member _____ ☐ Friend _____

☐ Social Media _____ ☐ Other: _____

RESPONSIBLE PARTY (If other than patient)

RELATIONSHIP TO PATIENT: ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

FULL LEGAL NAME: _____ **DOB:** _____

SOCIAL SECURITY NUMBER: _____ **GENDER:** ☐ Female ☐ Male

MAILING ADDRESS (If different from above):_____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **CELL PHONE:** _____ ☐ VM OK? ☐ Yes ☐ No

Employment Status: ☐ Employed ☐ Self-Employed ☐ Not Employed ☐ Retired ☐ Student

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INSURANCE

FOR US TO BILL YOUR INSURANCE COMPANY PROPERLY PLEASE FILL OUT FORM COMPLETELY.

PRIMARY INSURANCE: _____ ID #: _____

GROUP # _____

POLICY HOLDER NAME: _____ RELATIONSHIP TO PATIENT:_____

DOB (MM/DD/YYYY): _____ SOCIAL SECURITY NUMBER : _____

SECONDARY INSURANCE: _____ ID #: _____

GROUP # _____

POLICY HOLDER NAME: _____ RELATIONSHIP TO PATIENT:_____

DOB (MM/DD/YYYY): _____ SOCIAL SECURITY NUMBER : _____

RELEASE and ASSIGNMENT AND AUTHORIZATION TO RELEASE INFORMATION: Giving us permission to leave a voicemail , text message or email which includes what may be protected health information (i.e.: test results ,appointment reminders etc.) UNLESS STATED OTHERWISE, WE Will POTENTIALLY MAIL INFORMATION TO THE ADDRESS YOU PROVIDE.

I, the undersigned have insurance coverage and assign directly to Palo Verde Plastic Surgery all medical benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by said insurance unless assignee has executed an agreement with my insurance provider or plan. I understand that if such agreement has been executed, I am responsible to pay any deductible and/or co-payment and non-covered services under the terms of my insurance. I understand that I am financially liable in the event of non-payment. I authorize payments of medical benefits to the provider for services rendered , or to be rendered in the future, without obtaining my signature on each claim submitted , and I will be bound by the signature as though personally signed the claim. I agree to pay the collection agency's cost and/or court cost and reasonable attorney fees.

By Signing below , I have read ,understand and agree to all the above and that the information I have given is correct.

PATIENT/RESPONISBLE PARTY PRINTED: _____

PATIENT/RESPONISBLE PARTY SIGNATURE: _____

DATE: _____