

JAMES D. WETHE, MD – American Board of Plastic Surgery

PATIENT INFORMATION

Name Age Sex

Address City State Zip Code

Home Phone # Cell Phone # E-mail Address

Social Security # Drivers License # Date of Birth

Employer Work Phone #

Employer Address

Emergency Contact Relationship Phone #

Referred by

OK to contact? Home Cell Work Email

INSURANCE INFORMATION

Primary Insurance: _____ Phone # _____

Address: _____

Policy # _____ Group # _____ Effective Date _____

Authorization for release of information

I hereby authorize James D. Wethe, M.D. to release information requested by my insurance company or Worker's Compensation carrier. I also authorize James D. Wethe, M.D. to release information to any hospital or physician I may be referred by this office.

Signature Date

Relationship To Patient

Assignment of Benefits

I hereby authorize assignment and payment directly to James D. Wethe, M.D., major medical benefits due me.

I HEREBY AGREE TO PAY ANY AND ALL CHARGES THAT EXCEED OR THAT ARE NOT COVERED BY INSURANCE.

Signature Date Relationship