Date: ___ /___ /___

MIRZAI / PHAN PLASTIC SURGERY

Todd H. M. Mirzai, M.D. – Bao L. Phan, M.D.

PLEASE WRITE OR PRINT CLEARLY

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: ____ /____ /____ Age: _____ SS#: _____ -_ ___ - _____ Sex: Male Female

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Phone: (_____)_____ - _____ ☐ Home ☐ Cell ☐ Work

E-mail: _____ ☐ Yes, Please include me in your monthly email promotions

Place of Employment: _____ Phone: (____)_____ - _____

Married / Single / Divorced Spouse: _____ Place of Employment: _____

Phone: (_____)_____ - _____

If patient is a minor, full-time student, or not the responsible party:

Guarantor: _____ Place of Employment: _____ Phone: (____)_____ - _____

Have you or another family member been seen in this office before? Yes No If yes, name: _____

Insurance information (if applicable)

Primary Insurance Co: _____ Policy #: _____ Phone: (____)_____ - _____

Insured Name: _____ Date of Birth: ___ /___ /___ SS#: _____ - ____ - _____

Secondary Insurance Co: _____ Policy #: _____ Phone: (____)_____ - _____

Insured Name: _____ Date of Birth: ___ /___ /___ SS#: _____ - ____ - _____

I UNDERSTAND THAT I AM RESPONSIBLE FOR CHARGES ARISING FROM SERVICES DELIVERED AND I AUTHORIZE PAYMENT OF ANY MEDICAL INSURANCE BENEFITS (IF APPLICABLE) TO MIRZAI / PHAN PLASTIC SURGERY. I CONSENT AND AUTHORIZE THE RELEASE OF ANY MEDICAL HEALTH INFORMATION NECESSARY FOR PURPOSES OF TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS NEEDED TO PROCESS THIS CLAIM (IF APPLICABLE).

Signature: _____ Date: _____

MEDICAL HISTORY

Are you allergic to any drugs for foods? List all ☐ Yes ☐ No

_____

Do you take any medications regularly? List all ☐ Yes ☐ No

_____

Do you take any non-prescription or herbal medications or use any illegal substances? List all ☐ Yes ☐ No