



JOSEPH R. BURLIN, MD, INC.

PLASTIC & RECONSTRUCTIVE SURGERY

1805 N. CALIFORNIA STREET, SUITE 405

STOCKTON, CA 95204

OFFICE: (209) 870-7100

FAX: (209) 870-7116

NEW PATIENT INFORMATION

PATIENT INTRODUCTION:

Date _____

Name _____ Date of Birth _____ Age _____
First Middle Initial Last

Street Address _____ Apt. # _____

City & State _____ Zip Code _____ Home Phone: _____

May we contact you by e-mail? Yes (Your e-mail address will be kept in strict confidence.) No

Cellular Phone: _____

If yes, E-mail address _____ Would you like to receive our newsletter? Yes No

Single Married Divorced Separated

If married, spouse's name _____ Patient's Social Security Number _____

Spouse's Social Security # _____ Patient's Driver's License Number _____

HAVE WE SEEN YOU BEFORE:

No Yes Approximate date(s): _____

Reason: _____

Referral Source: _____

How did you learn about our office: _____

REASON FOR TODAY'S VISIT:

EMPLOYMENT DATA:

Patient's Employer _____ Spouse's Employer _____

Employer's Address _____ Employer's Address _____

Telephone # _____ Telephone # _____

Job Title _____ Spouse's Job Title _____

Insurance Carrier _____ Insurance Carrier _____

Group Number _____ Group Number _____

I. D. Number _____ I. D. Number _____

AUTHORIZATION AND CONSENT FOR PHOTOGRAPHY

I hereby consent that photographs may be taken of me for the purpose of medical records. These photographs may also be employed for educational and research purposes to physicians and other health professionals. I understand that my name will never be included with said photographs. I waive any right to compensation for such uses of photographs and hold Joseph R. Burlin, MD, Joseph R. Burlin, MD, Inc., and the Plastic Surgery Center of Stockton harmless from any activities authorized by this agreement. A photocopy of this authorization is valid as the original.

Signature _____

Date _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment of all medical and/or surgical insurance benefits directly to Joseph R. Burlin, MD, Inc., for professional services performed. A photocopy of this authorization is valid as the original.

Signature _____

Date _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize release of any and all medical records and information directly to Joseph R. Burlin, MD, INC., 1805 N. California Street, Suite 405, Stockton, California 95204, with particular reference to (see below):

Patient Name: _____

Date of Birth: _____

Patient Signature: _____

Former Name(s): _____

Approximate Date(s) of Care: _____

A PHOTOCOPY OF THIS AUTHORIZATION IS VALID AS THE ORIGINAL.