THOMAS G. CRABTREE, MD, FACS

— BOARD CERTIFIED PLASTIC & RECONSTRUCTIVE SURGEON —

Please print clearly

Patient Name: ______________________________ Date of Birth: ___/___/_____ Age: ______

Gender: _____F_____M Social Security ______________________________

Street Address: ____

City: ______________________ State: __________ Country: ____________ Zip: ____________

Home Phone: ______________________ Cell Phone: ______________________

Email Address: ______________________ Work Phone: ______________________

Employer: ______________________ Occupation: ______________________

Marital Status: ______________ Spouse Name (if Applicable): ______________________

Emergency Contact Name: ______________________________ Phone: ______________

Please indicate how we may contact you: Please Circle

Home Telephone/ Answering Machine Yes – No   Cell Phone/Voice Mail Yes - No

Work Telephone/Voice Mail Yes – No   Written Communication to home Yes - No

Primary Care Doctor: ______________________________ Phone: ______________________

Address: ____

Referring Doctor: ______________________________ Phone: ______________________

If this Appointment work or auto related: YES ______ NO _________

How did you hear about us: ____

Primary Insurance: ______________________/__________________/___________/________

Name of Insurance Company   Insurance Phone #   Referral Needed   Copay

______________/______________/__________/__________/__________

Policyholder's Last   First   Middle   Date of Birth   SS#

______________/______________/______________/______________

Insurance Contract #   Group #   Employer Name   Phone #

______________/__________/______/__________/______________

Address of Policyholder (if different from patient   City   State   Zip Code   Home Phone

Secondary Insurance: ______________________/__________________/___________/________

Name of Insurance Company   Insurance Phone #   Referral Needed   Copay

______________/______________/__________/__________/__________

Policyholder's Last   First   Middle   Date of Birth   SS#

______________/______________/______________/______________

Insurance Contract #   Group #   Employer Name   Phone #

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatment, and any plans for future care or treatment. I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I also allow fax transmittal of my medical records, if necessary. I acknowledge full financial responsibility for services rendered by Dr. Thomas G. Crabtree. I further authorize and request that insurance payments be made directly to Dr. Thomas G. Crabtree. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization. (If you would like a copy of our HIPPA notice please notify receptionist)

Signature: ____ Date: ______________

Parent or Guardian if Minor ____