



NEW PATIENT INFORMATION

Patient's Name

_____ Last First MI Nickname

Home Address

_____ Street & Apt # City State Zip

Home phone _____ Marital status: Single Married to _____ Other _____

SSN _____ DOB ____/____/____ Age ____ Sex: M F

Cell phone _____ Email _____

Patient's Employer _____ Occupation _____

Employer address

_____ Street & Apt # City State Zip

Work phone _____ Ext _____ May we contact you there? no yes

How did you hear about us? _____

Emergency Contact _____ Relationship to patient

Address

_____ Street & Apt # City State Zip

Home phone _____ Work phone _____ Cell phone _____

Primary Health Insurance _____ Copay? no yes Amount

\$ _____

Policy # _____ Group # _____

Employer _____

Insured: Name _____ SSN _____ DOB _____

SSN _____

Secondary Health Insurance _____ Copay? no yes Amt

\$ _____

Policy # _____ Group # _____

Employer _____

Insured: Name _____ SSN _____ DOB _____

SSN _____



TrüYou
Plastic and Reconstructive Surgery

I understand I am responsible for all customary charges incurred. Authorization is granted to furnish my insurance company all information requested concerning services billed. I hereby assign TruYou Plastic Surgery of Jacksonville all payments to which I am entitled from the above policies for medical/surgical expenses related to services received, and direct that the insurance company make no payment directly to me. In the event my insurance carrier does not accept Assignment of Benefits, or if payment is made directly to me or my representative, I will endorse such payment to TruYou Plastic Surgery of Jacksonville. I authorize my insurance carrier to release information regarding my coverage to TruYou Plastic Surgery of Jacksonville. I also authorize agents of any hospital, surgery center, or previous physician to furnish TruYou Plastic Surgery of Jacksonville copies of any records related to my treatment. A copy of this statement is considered the same as the original.

Patient signature _____ Date _____