

Today's Date _____

PATIENT INFORMATION

Name _____ ☐ Single ☐ Married ☐ Widowed
First Middle Last

Address _____ City _____ Zip _____

Home Phone _____ Cell _____ Work _____

Date of Birth _____ Age _____ Social Security # _____

Occupation/Employed By _____

Employer's Address _____

Email Address _____

Spouse or Parent's Name _____ Phone # _____

Date of Birth _____ Social Security # _____

Do you have a living will, advanced directive to physicians or surrogate decision maker? _____ Yes _____ No

IN CASE OF EMERGENCY – CONTACT

Name _____ Phone # _____

INSURANCE

Name of Insured _____ Employer _____

The above information is correct to my best knowledge. If applicable, I request that Dr. Caster file Medicare/Insurance claims and that payment of authorized benefits be made on my behalf to Dr. Caster/Oculofacial Plastic Surgery for any services furnished to me by the attending physician. I authorize the release of any medical information necessary to process Medicare and any Insurance Claim. I am aware that any balance not covered by my insurance will be my responsibility.

I authorize Dr. Caster/Oculofacial Plastic Surgery to release any information regarding my Medical History, Diagnosis, Care, Treatment, or Progress to the following:

We may release information to : _____

Patient Signature: _____ **Witness** _____