Rafael Gottenger, MD PA

Cosmetic and Reconstructive Plastic Surgery

Patient Information Form (Insurance)

Patient's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Other: _____

Email: _____ May we send promotional emails to you: ____ (no) ____ (yes)

Age: _____ Date of Birth: _____ SS#: _____ Gender: Male / Female

Marital Status: _____ (Single) _____ (Married) _____ (Other) _____ Race/Ethnicity:_____

Spouse/Partner's Name: _____ Phone: _____

Employer's Name: _____ Phone: _____

Emergency Contact: _____ Relationship to patient: _____

Home Phone: _____ Cell Phone: _____ Other: _____

Are you interested in joining our Loyalty program? ____ (Yes) ____ (No)

Person Financially Responsible: Patient _____ Parent: _____ Other: _____

If not parent or other, please complete the following:

Name: _____ Relationship to patient: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Other: _____

Insurance Information

Primary Insurance: _____ Policy #: _____ Group #: _____

Is the above Insurance Company your primary Insurance Company? YES NO Please Initial: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Name of Subscriber: _____ Relationship to Patient: _____

Birth Date: _____ Social Security #: _____

Primary Care Physician: _____ Telephone: _____

How did you hear about us? (Check all that apply)

___ Referred by a friend / relative ___ Referred by a doctor / physician ___ Referred by an organization

___ TV ___ Internet ___ Magazine

___ Email ___ Event ___ Other: _____

Name of referral source: _____

7330 SW 62nd Place, Suite 205, South Miami, Florida 33143

Phone: 305.669.0900 Fax 305.669.0100 e-mail: appointments@myplasticare.com

www.myplasticare.com