MICHAEL ECHAVEZ M.D.

Facial Plastic & Reconstructive Surgery
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Registration Form

PATIENT NAME_____
first middle initial last

DATE OF BIRTH_____ AGE_____ SOCIAL SECURITY # _____

HOME PH (_____) _____ BUSINESS PH (_____)_____ CELL PH (_____)_____

EMAIL _____

HOME ADRESS_____
street city state zip

BUSINESS ADRESS_____
street city state zip

FAMILY PHYSICIAN_____ PHONE_____

ALLERGIES_____

RESPONSIBLE PARTY INFORMATION
(If different from above)

NAME_____
first middle initial last

ADRESS_____
street apt # city state zip

PHONE (_____) _____ SOCIAL SECURITY # _____

EMPLOYER _____ PHONE (_____) _____

ADRESS_____
street city state zip

EMERGENCY CONTACT

NAME_____ RELATIONSHIP_____ PHONE (_____) _____

INSURANCE INFORMATION (If applicable)

SUBSCRIBER
NAME_____

SUBSCRIBER
D.O.B. _____

ADDRESS_____ PHONE (_____) _____

PRIMARY
CARRIER_____POLICY #_____ GROUP#_____

SECONDARY CARRIER_____ POLICY# _____ GROUP#_____

I hereby assign medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to: Michael Echavez, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information to secure payment.

signature of patient/parent/authorized person_____
date