

MICHAEL ECHAVEZ M.D.

Facial Plastic & Reconstructive Surgery
490 Post Street, Suite 542, San Francisco, CA 94102
415-392-9800 • sfplasticsurgery.com

Registration Form

PATIENT NAME _____
first middle initial last

DATE OF BIRTH _____ AGE _____ SOCIAL SECURITY # _____

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

HOME ADDRESS _____
street city state zip

BUSINESS ADDRESS _____
street city state zip

FAMILY PHYSICIAN _____ PHONE _____

ALLERGIES _____ EMAIL _____

RESPONSIBLE PARTY INFORMATION (If different from above)

NAME _____
first middle initial last

ADDRESS _____
street apt # city state zip

PHONE (_____) _____ SOCIAL SECURITY # _____

EMPLOYER _____ PHONE (_____) _____

ADDRESS _____
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# _____

CREDIT INFORMATION

VISA/MASTERCARD # _____

CARDHOLDER NAME _____ EXPIRATION DATE _____ BILLING ZIP _____

I hereby authorize you to roll over onto my account any balance due greater than \$75.00 _____
PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

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 be 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 _____