

**ALBERT DABBAH, MD, PA**

**PLASTIC MEDICAL, LLC**

**PATIENT INFORMATION SHEET**

PRIMARY PHYSICIAN: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

MR. MS. MRS. DR.

PRIMARY LANGUAGE SPOKEN \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

(IF YOU WANT TO RECEIVE SPECIAL OFFERS AND OUR NEWSLETTER)

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

SEX: M F MARITAL STATUS: S M W D

PHONE NUMBER: \_\_\_\_\_

ALTERNATE PHONE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

SPOUSE OR PARENT NAME: \_\_\_\_\_

EMERGENCY NAME AND CONTACT PHONE NUMBER: \_\_\_\_\_

I AUTHORIZE THE RELEASE OF MEDICAL OR OTHER INFORMATION ABOUT ME TO MY INSURANCE COMPANY, THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCE ADMINISTRATION OR ANY PHYSICIANS INVOLVED IN MY CARE. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS DIRECTLY TO PLASTIC MEDICAL, LLC.

I UNDERSTAND AND PERSONALLY GUARANTEE TO BE FINANCIALLY PAY FOR ANY AND ALL CHARGES NOT COVERED BY THIS ASSIGNMENT. AS A GUARANTOR, I FULLY ACCEPT THE MEDICAL SERVICES PROVIDED TO THE ABOVE NAMED PATIENT AS FULL CONSIDERATION FOR MY SIGNING THIS DOCUMENT. I ALSO REMAIN TOTALLY RESPONSIBLE TO THE BILL IF ANY INSURER INCLUDING MEDICARE OR HMO'S DENYING PAYMENT AS DEEMED UNNECESSARY, NOT REASONABLE, COSMETIC OR OTHERWISE. IN THE EVENT COLLECTION EFFORTS ARE REQUIRED TO OBTAIN PAYMENT OF THE CHARGES INCURRED BY THE PATIENT, I AGREE TO PAY ANY COSTS IN THE COLLECTION OF THE ACCOUNT.

I HEREBY AUTHORIZE DR. DABBAH, ALBERT DABBAH, MD, PA, PLASTIC MEDICAL, LLC AND ASSOCIATES TO TAKE PHOTOGRAPHS, VIDEO AND OTHER DOCUMENTARY IMAGES APPROPRIATE FOR MY CARE AND TO USE THESE IMAGES FOR PROFESSIONAL MEDICAL PURPOSES, MEDICAL AND LAY PUBLICATIONS, MEDICAL AND LAY EDUCATION, PATIENT EDUCATION OR DURING LECTURES TO MEDICAL OR LAY GROUPS. I UNDERSTAND THAT I WILL NOT BE ENTITLED TO ANY PAYMENT OR COMPENSATION AS A RESULT OF ANY USE OF PHOTOGRAPHS, VIDEOS OR OTHER IMAGES.

BY SIGNING BELOW, THE UNDERSIGNED CERTIFIES THAT THE FOREGOING PARAGRAPHS HAVE BEEN READ IN FULL AND ARE UNDERSTOOD BY THE UNDERSIGNED.

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_