DOWNEY
PLASTIC SURGERY
1536 N 115th St, Ste 105
Seattle, WA 98133
206-368-1160

**PLEASE COMPLETE ALL SECTIONS**

PATIENT NAME: DATE: _____

_____ Male ☐ Female ☐

FIRST MIDDLE LAST

Name you prefer to be called:

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Separated ☐ Divorced

Address: Apt # City Zip

Home Phone: ( ) Cell Phone: ( )

Social Security # Email:

Birthdate Age

Employer:

Work Phone: ( )

**Responsible Billing Party** / Relationship to Patient: ☐ Self ☐ Partner / Spouse ☐ Child ☐ Parent
(give address and phone if different than above)

Address: Phone: ( )

Spouse or Partner's Name / Parent's name (if patient is a minor):

Spouse, Partner, or Parent's work phone: ( )

***Whom shall we call in an emergency?*** (Please give name, relationship, area code and phone number of someone not living with you.)

**Primary Medical** Insurance Carrier: Member #:

Subscriber Name and Date of Birth Group #:

Medicare Number: Do you have an Advance Directive? ☐ Yes ☐ No

**Secondary** or Medicare Supplement Insurance Carrier: Member #:

Subscriber Name and Date of Birth Group #:

**Assignment and Release:** I hereby authorize my insurance benefits to be paid directly to Downey Plastic Surgery, PLLC. I am financially responsible for the balance due. I also authorize the practice or insurance company to release information required for this claim.

***If I have no insurance I agree to pay today for services provided by Downey Plastic Surgery, PLLC.***

I, the patient / patient's legal representative, hereby grant permission to Downey Plastic Surgery, PLLC to perform such examinations and medical or therapeutic procedures as may be deemed professionally necessary for my / the patient's diagnosis and treatment.

I acknowledge receipt of the Notice of Privacy Practices from Downey Plastic Surgery, PLLC.

Signature: _____ Date: _____