East End Plastic Surgery & Laser Center
Judy Ann Emanuele, M.D., F.A.C.S.

Patient Information *(please print)*

Name: _____
LAST *FIRST* *M.I.*

Mailing Address: _____

Town/City: _____ State: _____ Zip Code: _____

Phone Number: home_____ work_____ cell_____

E-mail Address:_____

Birth date: _____ Age: _____ Marital Status: _____

Social Security #: _____ Sex: ☐ Male ☐ Female

Employer: _____ Occupation: _____

Name of person to call in case of an emergency: _____

Relationship: _____ Phone #: _____

Please specify any restrictions you have to our office contacting you: _____

Would you like to be on our mailing/e-mail list to receive promotional offers from our office: ☐yes ☐no

Insurance Information

Primary Insurance Carrier: _____ I.D. #: _____

Policyholder's Name: _____ Relationship: _____

Policyholder's Date of Birth: _____ Policyholder's S.S. #_____

Secondary Insurance Carrier: _____ I.D. #: _____

Policyholder's Name: _____ Relationship: _____

Policyholder's Date of Birth: _____ Policyholder's S.S. #_____

Guarantor Information

Name of person that is financially responsible for this account? _____

Mailing Address: _____

Town/City: _____ State: _____ Zip Code: _____

Phone Number: home_____ work_____ cell_____

Guarantors D.O.B.:_____ Guarantors S.S. #:_____

Please present your insurance card(s) and driver's license/photo ID to the receptionist so copies may be made.

Authorization to Release Information
I hereby authorize East End Plastic Surgery & Laser Center to release any information acquired in the course of my treatment to process insurance claims and determine benefits payable.

Assignment of Benefits
In consideration of services rendered, I hereby authorize payment directly to East End Plastic Surgery & Laser Center the amount due from my insurance company for services rendered**. I understand that I am financially responsible for any balance not covered by my insurance carrier.** I also understand that I will be financially responsible for and agree to pay attorney fees which is equal to 1/3 of the total balance plus any processing fees that might be incurred to collect payment in full.

_____ _____
Patient / Responsible Party Signature *Date*