

GALLAS PLASTIC SURGERY

(281) 646-1114

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? No Yes E-mail _____

Contact Drivers License #
Restrictions: _____ (include State) _____

Age _____ Birthdate ____ / ____ / ____ SS# ____ - ____ Sex Female Male

Marital Status Single Married to: _____ Other: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? Yes No

Address _____
Street & Suite # City State Zip

Emergency Contact
(Not in your household) _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____
Street & Apt # City State Zip

Primary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? No Yes Copay? No Yes, \$ _____

Insured: Name _____ DOB _____ Employer _____

Secondary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? No Yes Copay? No Yes, \$ _____

Insured: Name _____ DOB _____ Employer _____

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Gallas to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Gallas and myself.

Signature _____ **Date** _____

How did you hear about Dr. Gallas? _____