J. DOUGLAS CUSICK, M.D., F.A.C.S., Inc.
BOARD CERTIFIED
Plastic, Cosmetic, Reconstructive
and Hand Surgery

Name:_____ Sex:_____ Age:_____ Birthdate:_____

Address:_____City:_____State:_____Zip:_____

Home phone #:_____Work phone #:_____Cell phone#:_____

E-Mail address:_____SS#:_____Marital status:____

Name of your primary physician:_____

Name of physician or person who referred you:_____

Reason for referral:_____

Does your insurance company require a referral form or authorization for care? If so, you must have it at the time of service, otherwise payment is due.

POLICYHOLDER / RESPONSIBLE PARTY INFORMATION:

Name:_____Relation to patient:_____

Social security #:_____Birthdate:_____

Employer name & address:_____

Is this workman's compensation?_____ Is this an auto accident?_____Date of accident:_____

Is an attorney involved?_____ Name and address of attorney:_____

Primary insurance:_____ Policy #:_____Group#:_____

Address and phone # of insurance carrier:_____

Secondary insurance:_____ Policy #:_____Group#:_____

Address and phone # of insurance carrier:_____

Contact person in case of emergency:_____

Home phone #:_____Work phone #:_____Cell phone#:_____

Other contact person not living with you:_____

Home phone #:_____Work phone #:_____Cell phone#:_____

Authorization to release information and authorization of benefits: I hereby authorize J. Douglas Cusick, MD. to release to my insurance company any information acquired during the course of my examination or treatment I also authorize payment be made directly to J. Douglas Cusick, M.D. I understand that I am responsible for any and all charges not paid by my insurance. Photographs may be taken and used for my record and/or educational purposes.

Patient's signature:_____Date:_____

Member
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