

Lisa J. Peters, MD

PLASTIC SURGERY • MEDICAL SPA

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Patient's Name

Last First Middle Prefers to be called

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ E-mail _____

Work _____ Preferred contact: Home Cell Work E-mail

Any restrictions for contacting you? No Yes If so, what restrictions _____

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

Relationship to Patient _____

Home Phone _____ Work Phone _____ Cell Phone _____

Primary doctor

Address _____

Phone _____ Fax _____

How did you hear about Dr. Peters?

ASPS: _____ Magazine: _____

Care Credit: _____ Website: _____ Seminar: _____

Newspaper: _____ Insurance: _____ Hospital: _____

Friend/Relative: _____ Doctor: _____ Other: _____

If you were referred by a specific person, may we thank them? Yes No Name: _____

INSURANCE INFORMATION:

Primary Co: _____ Insured Name: _____ DOB: _____

Policy # _____ Group # _____ Ins. Phone _____

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

Secondary: _____ Policy # _____ Group # _____

Ins. Phone _____

I understand and agree that (regardless of my insurance policy), I am responsible for the entire balance on my account, for all professional services provided to the patient (or myself). I also understand that if payments are not made on time, there will be service charges and interest will be added. I have read all the information contained in the financial policy. I certify that, to the best of my knowledge, this information is correct and true. I will notify this office in case of any changes to my health or any above information.

I hereby authorize the release of any medical information necessary to process my claim. I hereby authorize payment directly to the above physician of the surgical and/or medical benefits for her services.

Signature _____

Date _____