DATE ___/___/___

EDWIN AUSTIN MD, FACS
Plastic and Reconstructive Surgery
875 Oak Street SE
Suite 4060
Salem, OR 97301

REFERRED BY

PRIMARY CARE PHYSICIAN

PATIENT INFORMATION *(Please Print)*

GENERAL INFORMATION

PATIENT'S FIRST NAME	MIDDLE INITIAL	LAST NAME	BIRTHDATE ___/___/___
PATIENT'S ADDRESS (IF MAILING ADDRESS IS PO BOX, STREET ADDRESS REQUIRED ALSO)			SEX M F / AGE / ❑ SINGLE ❑ DIVORCED ❑ MARRIED ❑ WIDOWED
CITY		STATE	ZIP CODE
PATIENT'S PHONE	CELL PHONE		PATIENT'S SOCIAL SECURITY NUMBER
PATIENT'S EMPLOYER		EMPLOYER PHONE NUMBER	OCCUPATION

SPOUSE, GUARDIAN OR RESPONSIBLE PARTY INFORMATION

FIRST NAME	MIDDLE INITIAL	LAST NAME	BIRTHDATE ___/___/___	RELATIONSHIP TO PATIENT
EMPLOYER			SPOUSE'S SOCIAL SECURITY NUMBER	
HOME PHONE NUMBER	CELL PHONE NUMBER		WORK PHONE NUMBER	

NAME OF FRIEND OR RELATIVE NOT LIVING WITH YOU (ALTERNATE CONTACT REQUIRED)

NAME	RELATIONSHIP	PHONE NUMBER

INSURANCE

PRIMARY HEALTH INSURANCE

INSURANCE CO.			SUBSCRIBER
CLAIM BILLING ADDRESS			EMPLOYER
INS. PHONE NUMBER	GROUP #	I.D. #	CO-PAY

SECONDARY HEALTH INSURANCE

INSURANCE CO.			SUBSCRIBER
CLAIM BILLING ADDRESS			EMPLOYER
INS. PHONE NUMBER	GROUP #	I.D. #	

ACCIDENT

IS THIS AN ON-THE-JOB INJURY, AUTOMOBILE, OR HOUSEHOLD ACCIDENT?		INS. CARRIER
HOW DID INJURY OCCUR?		CLAIM NUMBER
DATE OF INJURY	IF UNABLE TO WORK, DATE LAST WORKED	ADJUSTER'S NAME
WHERE DID INJURY OCCUR? ❑ AT WORK ❑ AT HOME ❑ OTHER: EXPLAIN		ADJUSTER'S PHONE NUMBER
PREVIOUS DOCTORS SEEN FOR THIS INJURY		CLAIMS ADDRESS

_____ INITIAL HERE IF YOU WOULD LIKE TO BE ON OUR MAILING LIST

Assignment and release: I hereby assign my insurance benefits to be paid directly to Edwin N. Austin, M.D. I understand that I am financially responsible for non-covered services. I also authorize Dr. Austin and staff to release any information required to process this claim. I also consent to medical photography and authorize release for medically related purposes.

Signed _____ Date _____

Thank you for choosing our office!