

Parvaiz Malik MD F.A.C.S.

Plastic Surgery of Central Jersey, P.C.

Date _____

[PLEASE PRINT CLEARLY]

PATIENT INFORMATION

First Name _____ Initial _____ Last Name _____

Date of Birth _____ Age _____ Sex: M / F Marital Status: S M D W

Social Security # _____ Drivers License # _____

Race _____ Nationality _____ Language _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Occupation _____

Work Phone _____ XT _____ Preferred Contact: Home Cell Work Email

Email Address _____ Is it ok to call you at work? Yes / No

Emergency Contact: _____ Relation: _____ Phone: _____

Patient/Subscriber Employer: _____

Address: _____

How did you hear about Dr. Malik?

Doctor Friend/Family Internet/Website Name of Referrer: _____

REASON FOR VISIT

INSURANCE INFORMATION

Primary Insurance: _____

Policy # _____ Grp # _____ Ins. Phone: _____

Referral Required No Yes Co-Pay No Yes Co-Pay \$ _____

Subscriber: _____ Date of Birth: _____ SSN: _____

Secondary Insurance: _____

Policy # _____ Grp # _____ Ins. Phone: _____

Referral Required No Yes Co-Pay No Yes Co-Pay \$ _____

Subscriber: _____ Date of Birth: _____ SSN: _____

I hereby authorize you to bill my insurance company and that my insurance benefits are paid directly to Parvaiz Malik, MD or Plastic Surgery of Central Jersey. I agree that I am responsible for copayments, deductibles, and non-covered services. I understand that office visit charges are payable on the day service is rendered. Regardless of insurance coverage, I am responsible for all balances due for professional services in excess of the benefits provided by my insurance policy unless otherwise specified in the contract. I understand that my contract is between Dr. Malik and myself. I consent to having photographs taken for insurance or teaching and publications, after discussion with the doctor. The Notice of Privacy Practices is available upon request. I hereby authorize the release of pertinent medical information to insurance carriers for the purpose of billing.

Signature: _____

Patient / Parent / Insured / Guardian