KOLSTAD
FACIAL PLASTIC SURGERY

PATIENT DEMOGRAPHIC SHEET

Appointment Date:_____

Patient Name:_____Birth date: _____ Age:_____

Address:_____ City: _____ State: ____ Zip: _____

E-mail address:_____ SS#:_____

Home phone:_____ Cell phone:_____

May we contact you at work? Yes No Work phone:_____

Employer: _____ Occupation: _____

Employer address:_____ City:_____ State:_____ Zip: _____

Emergency contact person: _____ Relationship:_____

Contact address: _____City: _____ State: ____ Zip: _____

Contact phone: _____ Cell phone: _____Work phone: _____

Family Physician: _____ Phone: _____

Who referred you to us? Please check any and all that apply.

Physician
Name:_____

Word of Mouth/Friend
Name: _____

Internet
Google
Yelp
DrKolstad.com
RealSelf.com

Seminar

Newspaper
Name: _____

INSURANCE INFORMATION- REQUIRED

Policy holder's Name:_____ Relationship:_____

Aetna	Medicare
Blue Cross / Blue Shield	United
Cigna	Other:

Contract#:_____ Group#:_____ Contact person:_____

Insurance address:_____ City:_____ State:_____ Zip:_____

Insurance phone:_____

WORKERS'COMPENSATION INJURIES - IF APPLICALBE

WCB#:_____ Carrier Case #:_____ Date of injury:_____

Insurance Co:_____ Contact person:_____ Phone:_____

Insurance address:_____ City:_____ State:_____ Zip:_____

Employer at time of injury:_____

Employer address:_____ City:_____ State:_____ Zip:_____

Were x-rays taken? Yes No Where:_____ Date taken:_____

**In order to expedite your care; please have your x-ray films with you at your appointment.

AUTO ACCIDENT INJURIES- IF APPLICABLE

Date of accident:_____ Policy#:_____ Claim#:_____

Insurance Co:_____ Contact person:_____ Phone:_____

Insurance address:_____ City:_____ State:_____ Zip:_____

Policy holder:_____ Phone:_____

FISCAL POLICIES

It is the policy of Kolstad Plastic Surgery that payment for all office services are due on the date of service. We accept various forms of payment including cash, personal checks, money orders, and Visa or MasterCard. According of standard practice, full payment for cosmetic surgery is required three weeks in advance of surgery.

Cancellation of appointments must be made 48 hours prior to scheduled date or service fees will be charged to the patient.

I authorize payment of medical benefits to Kolstad Plastic Surgery for services rendered and release any medical information necessary to process the payment claim.

_____ _____

Signature of Insured or Authorized Person Date