Kids Plastic Surgery
experience • service • convenience

Mercy

*PRIMARY CARE PHYSICIAN*_____
*ADDRESS*_____
*Phone*_____ *Fax*_____

REFERING PHYSICAN _____
*ADDRE*_____
*Phone*_____ *Fax*_____

Patient			
Patient Social Security #	**Last Name**	**First Name**	**MI**
Address	**City**	**State**	**Zip**
Date of Birth / /	**Sex** ☐Male ☐Female	**Student Status** ☐Non-Student ☐Full-time ☐Part-time	

Family Information			
Mother's Full Name		**Date of Birth**	
Address	**City**	**State**	**Zip**
Home Phone: ( )	**Cell Phone:** ( )	**Work Phone:** ( )	**Email address:**
Employer		☐Full-time ☐Part-time	
Father's Full Name		**Date of Birth**	
Address	**City**	**State**	**Zip**
Home Phone: ( )	**Cell Phone:** ( )	**Work Phone:** ( )	**Email address:**
Employer		☐Full-time ☐Part-time	
Parents' Marital Status: ☐ Married ☐ Divorced ☐ Widowed			
If divorced, do both parents have custody and/or visitation rights? ☐ Yes ☐ No			
If no, please provide court documentation regarding the denial of parental rights.			

Other Information
Patient lives with:
Child is in: ☐ **Public School** ☐ **Private School** ☐ **Home Schooled** **Grade Level:**
Have there been any recent events at home or in the child's life that may affect his/her health or well being?

Responsible Party (Who is responsible for the remaining balance on this account?)			
Social Security Number	**Last Name**	**First Name**	**MI**
Address	**City**	**State**	**Zip**
Home Phone ( )	**Work Phone** ( )	**Name of Employer**	
Employer's Address	**City**	**State**	**Zip**
Date of Birth / /	**Sex** ☐Male ☐Female	**Marital Status** ☐(**M**)arried ☐(**S**)ingle ☐(**D**)ivorced ☐(**W**)idowed ☐(**L**)ife Partner	
Relation to Patient ☐Parent ☐Guardian ☐Other			

Primary Insurance			
Insurance Company Name	**Subscriber's Name**	**Subscriber's Social Security Number**	
Subscriber's Relationship to Patient ☐Self ☐Spouse ☐Parent ☐Guardian ☐Other	**Subscriber's DOB** / /	**Subscriber's Sex** ☐Male ☐Female	
Subscriber's Employer	**Patient's ID #**	**Group #**	**Copay Amount**
Employer Address	**City**	**State**	**Zip**
Insurance Company Address	**City**	**State**	**Zip**

Secondary Insurance			
Insurance Company Name	**Subscriber's Name**	**Social Security Number**	
Subscriber's Relationship to Patient ☐Self ☐Spouse ☐Parent ☐Guardian ☐Other	**Subscriber's DOB** / /	**Subscriber's Sex** ☐Male ☐Female	
Subscriber's Employer	**Patient's ID #**	**Group #**	**Copay Amount**
Employer Address	**City**	**State**	**Zip**
Insurance Company Address	**City**	**State**	**Zip**

Yes, I give permission for Kids Plastic Surgery staff to give detailed information regarding my treatment via:

☐ **Answering machine @**_____

☐ **Mail** ☐ **Email** _____