Douglas M. Monasebian, M.D., D.M.D., F.A.C.S., P.L.L.C.
Park Avenue Plastic Surgery
Park Avenue Specialty Care Office Based Plastic Surgery, P.L.L.C.

PATIENT INFORMATION

Last Name____________________________
First Name____________________________

Address ______________________________
____
____

E – Mail ______________________________

Home telephone________________________
Work telephone________________________
Mobile telephone_______________________

Who referred you to our office?
If Physician please provide address and telephone number below.

Name________________________________
Address______________________________
City/Zip/State__________________________
____
Telephone_____________________________

Date ____________________________
S.S. # ____________________________

Date of Birth______________Age________
Marital Status ________________________
Please Circle One: Male Female

Primary Policy Holder________________
Employer____________________________
Office Telephone_____________________
Address_____________________________
____

Physician____________________________
Dentist ____________________________

Person to notify in case of emergency
____

Relation______________________________
Telephone____________________________

NYS Drivers License#________________

INSURANCE INFORMATION (INSURANCE / SELF PAY)

Primary Insurance ____________________
Pol. Holder (if not you) ____________________
Relation to Insured ____________________
Secondary Insurance ____________________

Policy# ____________________
S.S.# ____________________
Ins.'s DOB ___________________
Policy# ____________________

I understand that I am financially responsible for all charges including the allowable balance remaining after reasonable and customary payment by my insurance carrier. I am responsible for all co-pays and deductibles as delineated by my insurance carrier. All deductibles must be paid prior to surgical procedure.

Assignment of benefits: I authorize payments of medical and government benefits made directly to Douglas M. Monasebian, M.D., D.M.D., and authorize release of medical information necessary to process this claim.

Signed______________________________ Date________________________________

Assignment of benefits: I authorize payments of medical and government benefits made directly to Park Avenue Specialty Care and authorize release of medical information necessary to process this claim.

Signed______________________________ Date________________________________