Jack T. Peterson, Jr., M.D., F.A.C.S.
Diplomate American Board of Plastic Surgery
Diplomate American Board of Otolaryngology
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PATIENT INFORMATION

Last Name _____First Name_____M.I.____Suffix_____

Address_____City_____State_____Zip_____

Home Phone( )_____Sex: M F Marital Status: S M W D Other _____

If you wish to receive cosmetic info via email please provide your email address

_____

How did you hear about Dr. Peterson_____

Date of Birth _____ Social Security #_____ Student Y N

Referring Doctor_____ Primary Care Doctor_____

Employer_____ Address_____

City_____State_____ Zip_____Phone_____

Primary Insurance_____ Health W Comp Auto Other

Insured's Name_____ Date Of Birth_____
Relationship to Patient_____

ID Number _____ Group Number_____
Referral Required Y N (if yes did you contact your PCP Y N
Secondary Insurance _____ Health Auto
Insured's Name_____ Date of Birth_____
Relationship to Patient_____

Responsible Party _____SSN # _____
Address_____
Employer_____Relationship to Patient_____
Home Phone_____ Work Phone _____
Emergency Contact_____Relationship to Patient_____
Home Phone_____ Work Phone_____

Authorization of Benefits to Physician
I hereby authorize direct payment of benefits to The Center For Plastic Surgery, P.A. and Jack T. Peterson Jr., M.D. I understand I am financially responsible for all charges incurred during the course of my treatment by Dr. Peterson, regardless of insurance coverage. I consent to examination and treatment by Dr. Peterson including medical photographs as necessary and I authorize the release of any information required by my insurance companies.

Patient/Parent Signature_____Date_____