MICHAEL ECHAVEZ M.D.

Facial Plastic & Reconstructive Surgery
500 Sutter St., Suite 430, San Francisco, CA 94102
415-392-9800 • sfplasticsurgery.com

Registration Form

PATIENT NAME____
first middle initial last

DATE OF BIRTH______________________AGE___________ SOCIAL SECURITY # (If using insurance)________________________

HOME PH (_______) ______________________ BUSINESS PH (_______)____________________ CELL PH (_______)____________________

HOME ADDRESS ____
street city state zip

BUSINESS ADDRESS ____
street city state zip

ALLERGIES ______________________________ EMAIL ______________________________

FAMILY PHYSICIAN______________________________ PHONE ______________________________

RESPONSIBLE PARTY INFORMATION
(If different from above)

NAME____
first middle initial last

ADDRESS ____
street apt # city state zip

PHONE (________) ______________________________ SOCIAL SECURITY # ______________________________

EMPLOYER ______________________________ PHONE (_______) ______________________________

ADDRESS ____
street city state zip

EMERGENCY CONTACT

NAME______________________________ RELATIONSHIP______________________________ PHONE (______) ____________________

INSURANCE INFORMATION (If applicable)

SUBSCRIBER
NAME ______________________________

SUBSCRIBER
D.O.B. ______________________________

ADDRESS ______________________________ PHONE (_______) ______________________________

PRIMARY
CARRIER ____________________________ POLICY #____________________________ GROUP#____________________________

SECONDARY CARRIER____________________ POLICY# ____________________________ GROUP#____________________________

I hereby assign medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to: Michael Echavez, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information to secure payment.

signature of patient/parent/authorized person____
date