COMMONWEALTH
PLASTIC SURGERY
Jared Nimtz, MD

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Tel 859.277.9435
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PATIENT INFORMATION

NAME (Last First Middle)	SSN#	BIRTHDATE	AGE	SEX

LOCAL ADDRESS	CITY, STATE, ZIP

HOME PHONE	WORK PHONE	ALTERNATE PHONE (CELL)

EMAIL

REFERRING PHYSICIAN	PRIMARY CARE PHYSICIAN

PRIMARY EMPLOYER	ADDRESS	CITY, STATE, ZIP

EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE NUMBER

WITH WHOM MAY WE DISCUS YOUR HEALTH INFORMATION?

☐ NO ONE OTHER THAN SELF ☐ SPOUSE ☐ PARENT ☐ VOICEMAIL (CELL/HOME) ☐ OTHER (Name) _____

MAY WE LEAVE DETAILED PERSONAL HEALTH INFORMATION ON YOUR CONTACT PHONE NUMBER VOICE MAIL?
THIS INFORMATION MAY INCLUDE PATHOLOGY RESULTS, LAB RESULTS, APPOINTMENTS, ETC.

HOME PHONE: ☐YES ☐ NO ALTERNATE PHONE: ☐YES ☐ NO BUSINESS PHONE: ☐YES ☐ NO

CAN WE NOTIFY YOU OF SPECIALS AND EVENTS VIA EMAIL? ☐YES ☐ NO

PHARMACY OF CHOICE: _____

HOW DID YOU HEAR ABOUT OUR PRACTICE? ☐ PHYSICIAN_____ ☐ FRIEND/FAMILY_____ ☐ OTHER _____

RESPONSIBLE PARTY INFORMATION (FOR MINOR PATIENTS)

NAME (LAST FIRST MIDDLE)	SSN#	BIRTHDATE/AGE	SEX

ADDRESS	CITY, STATE, ZIP

HOME PHONE	DAY PHONE	RELATIONSHIP TO PATIENT

I hereby give my permission to Commonwealth Plastic Surgery for the evaluation and treatment of the presented surgical condition.

I hereby authorize the above physician(s) to release information regarding services rendered by him/her and allow a photocopy of my signature to be used to file insurance.

I hereby authorized the physician(s) indicated above to furnish information to insurance carriers concerning my visit, and I hereby irrevocably assign all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

I have read the financial and privacy policy statements for Commonwealth Plastic Surgery and agree to the terms herein. I also understand that such terms may be amended when needed by the practice.

_____ _____

Patient or Responsible Party **Date**