FORM I

HEALTH INSURANCE ASSIGNMENT

SCULTURA PLASTIC SURGERY

Patient Name _____ Date _____

Birth date _____ SS# _____

Responsible Party ❑ Patient Is Responsible - Information provided on FORM F: GENERAL HEALTH HISTORY

Name _____ Relationship _____

Birth date _____ SS# _____

Address _____ City _____

State _____ ZIP _____ E-Mail _____

Home Telephone _____ Work Telephone _____

Employer: _____

Address _____

Primary Insurance Company: _____

Address _____ City _____

State _____ ZIP _____ Telephone _____

Policy Number _____ Group Number _____

Secondary Insurance Company: _____

Address _____ City _____

State _____ ZIP _____ Telephone _____

Policy Number _____ Group Number _____

FORM I

HEALTH INSURANCE ASSIGNMENT

ASSIGNMENT OF BENEFITS STATEMENT

I request that payment of authorized benefits be made payable to Scultura Plastic Surgery, for any services furnished me by J. Bradley Strawn, MD. I authorize Scultura Plastic Surgery to release to the Insurer and its agents any information needed to determine these benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

Patient signature or parent/guardian if the patient is a minor

Date

PLEASE PROVIDE YOUR DRIVERS LICENSE AND INSURANCE CARDS