Antoine A. Hallak, MD FACS

Plastic and Reconstructive Surgery

Cosmetic Surgery

Patient Information

Patient Name: _____

Last First MI

Address: _____

City State Zip

Home Phone: (_____)_____Work (_____)_____Cell_(_____)_____

Social Security: _____ Date of birth: _____

Please circle: Male Female Marital status: Married Single Divorced Widow

Primary Care Physician: _____ Phone: (_____)_____

Emergency Contact: _____ Phone: (_____)_____

Primary Insurance: _____ Secondary: _____

Subscriber to Insurance: _____ Date of birth: _____

Policy ID nbr: _____ Group: _____

Email Address:_____

I hereby authorize the release of any medical documents or information necessary to process a claim and I authorize payment of medical benefits to Antoine A. Hallak, MD for services rendered.

I also authorize the office of Dr Hallak to collect any applicable and unmet deductibles in case of elective non emergent surgical treatment prior to surgery date.

_____

Signature Date