Kimball M. Crofts, M.D.

Patient Information

MEMBER
AMERICAN SOCIETY OF PLASTIC SURGEONS

Patient Introduction

Patient Name: Last	First	M.I.	Todays Date

Address	City	State	Zip

Age	Sex	Birthdate	Status			HomePhone
			❑ Single	❑ Married	❑ Widowed	
				❑ Divorced	❑ Separated	

Social Security #	E Mail	I would like email reminders of future appointments	Work Phone
		❑ Yes ❑ No	

ReferredBy	Mobile Phone	I would like text reminders of future appointments	
		❑ Yes ❑ No	

Reason for Visit

If Accident: How?	When?	Where?

Responsible Party

Name	Relationship to Patient	Home Phone

Home Address	City	State	Zip

Social Security #	Employer	Business Phone

Primary Insurance Information

Insurance Co.	Policyholder	Patient Relationship to Insured			
		Self	Spouse	Child	Other

Insurance Co. Address	Birthday of Policyholder	Insurance Phone

Social Security # or ID #	Group #	Workers Comp Claim#

Secondary Insurance Information

Insurance Co.	Policyholder	Patient Relationship to Insured			
		Self	Spouse	Child	Other

Insurance Co. Address	Birthday of Policyholder		Insurance Phone	
	Self	Spouse	Child	Other

Social Security # or ID #	Group #

Authorizations

I hereby authorize release of information for insurance claim purposes.

BENEFITS TO PHYSICIAN:I hereby authorize insurance payments directly to the physician of the surgical and or medical benefits. I also understand I am responsible for any portion of my bill not covered by my insurance company and I agree to pay interest at a rate of 1 1/2% per month (18% annum) on an unpaid balance over 30 days old. I agree to pay all lawful collection costs, including court and attorneys fees should my account be turned over for collection. I understand the office will preauthorize my surgery as a courtesy. I have been notified that preauthorization is not guarantee of payment and accept responsibility of any unpaid amount. I am encouraged to call my insurance company and verify prior authorization and benefits of my procedure. I understand it is my responsibility to obtain a referral to Dr.Crofts if it is required by my insurance policy.

I also understand that photographs may be taken in the management of my case.

I understand all the above and hereby state that the information is correct to the best of my knowledge. My signature indicates that I have read the above and grant the request of the authorization and also agree to honor billing policies as outlined in the treatment, payment and health care operation consent.

Signed: _____ Date: _____