SOMERSET PLASTIC SURGERY

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Print Legibly

Patient's Name: Last:_____ First:_____ MI:_____

Address _____
Street & Apt # City State Zip

Age _____ Birthdate____/____/_____ SS#: _____-_____-_____ Sex ☐ Female ☐ Male

☐ Single ☐ Married Spouse: _____ ☐ Other _____

Home #: _____[ ]Cell #: _____[ ]Other # _____[ ] Please [✓]preferred contact #

E-mail _____ Driver's License #: _____ State _____

Emergency Contact _____ Relationship to Pt: _____
(Not in your household)

Phone # _____ Address: _____

Patient's Employer _____ Occupation_____

Work Phone _____Ext: _____ Is it okay to call you at work? ☐ No ☐ Yes

Spouses Employer _____ Occupation_____

RACE: ☐ White/Caucasian ☐ Black/African American ☐ Asian ☐ Hispanic ☐ Other_____ LANGUAGE: ☐ English ☐ Spanish ☐Other_____
Race is a federal requirement mandated by CMS-Centers for Medicare & Medicaid Services – Appropriate Box(s) must be marked

Referred By: _____

Phone # _____ Address: _____

Primary Care Physician _____

Phone # _____ Address: _____

Primary Health Insurance Company:_____

Policy #: _____Group #: _____ Copay? ☐ No ☐ Yes $_____ Referral Required? ☐ No ☐ Yes

Subscriber: Name: _____ DOB: ____/___/____ Subscriber SS#: _____-_____-_____

Secondary Health Insurance Company _____

Policy #: _____Group #: _____ Copay? ☐ No ☐ Yes $_____ Referral Required? ☐ No ☐ Yes

Subscriber: Name: _____ DOB: ____/___/____ Subscriber SS#: _____-_____-_____

Authorization to pay benefits to physician and release of medical information: I hereby authorize payment directly to Michael J. Busuito, M.D., of any surgical and/or medical benefits otherwise payable to me for his services. I hereby authorize Dr. Busuito to release any medical information necessary for payment on my insurance claim. I understand I am responsible for payment of all copays and deductibles as required by my insurance company.

Signature _____ **Date** _____