Jon Caster, MD, FACS *Oculofacial Plastic Surgery, PLLC*

Today's Date ________________________________

PATIENT INFORMATION

Name ____ ❒Single ❒Married ❒Widowed
First Middle Last

Address_____________________________________ City ___________________________ Zip______________

Home Phone ______________________ Cell _________________________ Work ________________________

Date of Birth __________________________ Age _______ Social Security # _____________________________

Occupation/Employed By ____

Employer's Address ____

Email Address ____

Spouse or Parent's Name _____________________________________ Phone # ____________________________

Date of Birth ___________________ Social Security # ____________________________________

Do you have a living will, advanced directive to physicians or surrogate decision maker? ________ Yes ________ No

IN CASE OF EMERGENCY – CONTACT

Name ____ Phone # ________________________________

INSURANCE

Name of Insured __________________________________ Employer ____________________________________

The above information is correct to my best knowledge. If applicable, I request that Dr. Caster file Medicare/Insurance claims and that payment of authorized benefits be made on my behalf to Dr. Caster/Oculofacial Plastic Surgery for any services furnished to me by the attending physician. I authorize the release of any medical information necessary to process Medicare and any Insurance Claim. I am aware that any balance not covered by my insurance will be my responsibility.

I authorize Dr. Caster/Oculofacial Plastic Surgery to release any information regarding my Medical History, Diagnosis, Care, Treatment, or Progress to the following:

We may release information to : ____

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Patient Signature: ________________________________ Witness ______________________________________