

PLASTIC SURGERY CENTER, PC
MICHAEL A. TOLSON, MD, FACS

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770-888-2999 FAX 770-888-4008
Toll Free 1-877-404-5954

PATIENT INFORMATION

FULL NAME _____ SEX _____ AGE _____ D.O.B. _____

ADDRESS _____ CITY _____ STATE _____ ZIPCODE _____

MARITAL STATUS: **Please circle one** Single Married Divorced Widowed

Race: _____ Home Phone # _____ Cell Phone # _____

Social Security # _____ - _____ - _____

Employer _____ Occupation _____

Address _____ Work # _____

City _____ State _____ Zipcode _____

Spouse's Name _____

Emergency Contact (not living with you)

Name _____ Phone # _____

Relationship _____

Address _____ City _____ State _____ ZipCode _____

If patient is a minor, please complete this section:

Father's Name _____ Employer _____ Phone # _____

Mother's Name _____ Employer _____ Phone # _____

Person responsible for bill (if other than patient):

Name _____ Relationship to patient _____

Address _____ City _____ State _____ ZipCode _____

REFERRAL SOURCE (please complete)

ADVERTISEMENT _____

FRIEND _____

PHYSICIAN _____

OTHER _____

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Michael Tolson to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Michael Tolson and myself.

Signature _____ Date _____