ARTISTIC PLASTIC SURGERY CENTER
Thomas G. Griffith, MD
Certified American Board of Plastic Surgery
American Society For Aesthetic Plastic Surgery

Date ____________
Referred By: ____________
Dr. Phone No. ____________
Account No. ____________

Name: ____________ Date of Birth: ____________ Age: ____________
Social Security No. ____________ Mr. ____ Ms. ____ Mrs. ____ Miss ____ Other ____
Home Phone: ____________ Cell Phone: ____________
Address: ____________
City: ____________ State: ____________ Zip: ____________
Employer: ____________ Work Phone: ____________
Address: ____________ State: ____________ Zip: ____________
Emergency Contact: ____________ Phone: ____________ Relation: ____________

PLEASE FILL IN THE BELOW PORTIONS IF APPLICABLE

Spouse's Name: ____________ Date of Birth: ____________ SSN: ____________
Employer: ____________ Work Phone: ____________
Father's Name: ____________ Date of Birth: ____________ SSN: ____________
Employer: ____________ Work Phone: ____________
Mother's Name: ____________ Date of Birth: ____________ SSN: ____________
Employer: ____________ Work Phone: ____________

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative or other individual to the extent necessary to help with your health care or with payment for your health care. List below individuals to whom we MAY NOT release personal health information:

Name: ____________ Relationship: ____________
Name: ____________ Relationship: ____________
Name: ____________ Relationship: ____________

INSURANCE INFORMATION

Primary		Secondary	
Plan Name:		Plan Name:	
Subscriber:		Subscriber:	
Address:		Address:	
City/State/Zip:		City/State/Zip:	
ID:	Group:	ID:	Group:
Co-Pay: $	Phone:	Co-Pay: $	Phone:

On the job injury? ☐ Yes ☐ No Claim No. ____________ Date of injury:
How did the accident occur? ____________ Where? ____________

NW 9/2009