

FRED L. HACKNEY, M.D., P.A.
Plastic and Reconstructive Surgery

PATIENT INFORMATION

(Please Print)

Today's Date ___/___/___

Name _____
Last First M.I.

Address _____
Street City State Zip

Email Address _____ Home Phone _____

Would you like to be on our mailing list? Yes _____ No _____

Work Phone _____ Cell Phone _____ SS# _____

Driver's License # _____ Birth Date ___/___/___ Age _____ Male () Female ()

Employer/School _____ Occupation _____

Address _____

Marital Status: Married Single Divorced Widow Separated

Spouse's Full Name: _____

In case of Emergency, who should be notified? _____

Relationship to Patient _____ Phone _____

Whom may we thank for this referral? _____

Address _____

Friend Doctor Former Patient Other _____

Primary Care Physician _____
Name Address Phone #

RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)

Name _____
Last First M.I.

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ SS# _____

Birth Date ___/___/___ Relationship to patient _____

INSURANCE INFORMATION

Primary Ins Name _____
Name of Insured _____
Date of Birth _____
Relationship of patient to the insured _____
Employer Name _____

Secondary Ins Name _____
Name of Insured _____
Date of Birth _____
Relationship of patient to the insured _____
Employer Name _____

I, _____, AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO FRED L. HACKNEY, M.D., P.A., AND AGREE TO RELEASE INFORMATION NECESSARY FOR PROCESSING. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF SERVICES AND REASONABLE COSTS OF COLLECTION.

I, _____, HAVE READ OR RECEIVED A COPY OF DR. FRED HACKNEY'S NOTICE OF PRIVACY PRACTICES. (There is a "Notice" located in the waiting room)