

Welcome to Plastic Surgery of Southern Connecticut, L.L.C.

Joseph B. O'Connell, M.D., F.A.C.S.

Patient's Last Name	First Name, Middle	Date
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Date of Birth	Age	Marital Status	E-Mail Address
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Address – Street	City	State	Zip
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Home Telephone	Daytime Telephone	Cell Phone No.
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Referred By (please indicate physician's name, name of other source or how you heard about us)	Business Phone
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Employed By	Employer's Address	Occupation
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Name of Spouse	Employed By	Employer's Address	Occupation
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In Case of Emergency Notify	Relationship to Patient	Telephone
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Known Allergies including medication allergies, allergies to anesthetics and latex allergy

MEDICAL INSURANCE INFORMATION

Policyholder's Name	Address	City	State	Zip
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Policyholder's Home Telephone Number	Relationship to Patient	Occupation
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Plastic Surgery of Southern Connecticut, L.L.C. is committed to protecting the confidentiality of all personally identifiable information including social security numbers, driver's license numbers, credit or debit card numbers, bank account numbers, identification card numbers and health insurance numbers collected in the course of business. Access to this information is limited to those employees and others whose duties require such knowledge. Employees of this Company are prohibited from disclosing, directly or indirectly, such personally identifiable information to anyone unless there is a lawful business justification for the disclosure. Note: This Company does not collect social security numbers.

PATIENT'S AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND CLAIM PAYMENT AUTHORIZATION

I hereby authorize Plastic Surgery of Southern Connecticut, L.L.C. to release any medical information, including medical photographs and confidential health information to my insurance carriers and to allow a photocopy of my signature to be used to file insurance claims. I hereby authorize and direct payment of insurance benefits due for the services provided by Plastic Surgery of Southern Connecticut, L.L.C. directly to Plastic Surgery of Southern Connecticut, L.L.C. I understand that, regardless of insurance benefits, I am financially responsible for fees for all services rendered and agree to reimburse Plastic Surgery of Southern Connecticut, L.L.C. for any attorney and court costs necessary to collect outstanding fees. I understand that balances over 30 days due will accrue interest at 1.5% per month.. *I also understand that unless specifically informed otherwise, the physicians of Plastic Surgery of Southern Connecticut, L.L.C. do not participate contractually with any managed care entity, HMO or insurance company.*

Signature _____ Date _____