YARROW BAY
PLASTIC SURGERY

5209 Lake Washington Blvd., Suite 115 Kirkland, WA 98033
(T) 425-822-0300 (F) 425-822-4999

Today's Date: ______________________ Patient DOB: _____________ Age: _______

Patient Name: ____ SSN: _________________________
(First) (MI) (Last)

Address: ____
(Street) (Unit/Apt#)

____
(City) (State) (Zip)

Gender (please circle): M / F Marital Status (please circle): S / M / D / P / W / Other

Phone Numbers: (Home) ___________________ (Work) ___________________ (Mobile) ____________________
May we leave a message? Y / N Y / N Y / N

My preferred phone number is my (please circle): Home / Work / Mobile

Email Address: ____________________________ Referring Doctor, If Applicable: __________________________

Patient Employer: __________________________ Occupation: ____

Emergency Contact: ______________________ Phone: _________________ Relationship to Pt: ________________

How/From whom did you hear about Yarrow Bay Plastic Surgery? ____
If referred by a patient, may we thank them? Y / N

COPY OF INSURANCE CARD(S) WILL BE PLACED HERE (IF APPLICABLE TO APPT)- PLEASE BRING INS CARD(S) AND PHOTO ID

If you are **NOT** the subscriber on your insurance policy, we need the following information of the **primary insured party**:

Full First and Last Name: ___________________________________DOB: __________________________ Gender: M / F
Primary Insured Employer: __________________________________ Relationship to patient: _________________________

If you have a Labor and Industries Claim, please provide the following:
Claim # _______________ Date of Injury: ____________Employer: ___________________ Phone: ______________________

I hereby authorize payment of any surgical and/or medical benefits be paid directly to the physician for services. I also agree to pay all charges that exceed or are not covered by insurance and authorize release of information to the insurance company. I also authorize the physician to disclose information to those individuals qualified for the purpose of medical quality and peer review.

Fees charged for your medical and surgical care are based upon what is usual and customary for our area as well as a relative value system. You are responsible for payment of fees regardless of any insurance company's arbitrary determination of what it feels is usual and customary. In the event that we place a claim for unpaid fees for collection, you agree to pay all costs of collection including, but not limited to, reasonable attorney's fees.

A fee of $25 will also be added to your account for any checks that are returned.

Signature: ____ Date: ______________________