

Gawley Plastic Surgery, Inc.

Bryan W. Gawley
8913 E. Bell Rd, Bldg. E, Ste.101
Scottsdale, Az 85260

Date: _____

Please Print

Patient Name (Last) _____ (First) _____ (M) _____

Local Address _____ City _____ State _____ Zip _____

Permanent Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Birthdate _____ Sex ? M ? F Marital Status _____ Age _____

Social Security _____ Drivers License _____

Employer _____ Occupation _____

In case of emergency contact _____ Relationship _____ Phone _____

How did you hear about us? _____ Email _____

If we are billing your insurance company please complete the following:

Primary Insurance Company: _____ Insurance Phone: _____

Policy #: _____ Group# _____ Employer _____

Policy Holder's Name _____ DOB _____ SSN _____

Secondary Insurance Company: _____ Insurance Phone: _____

Policy#: _____ Group# _____ Employer _____

Policy Holder's Name _____ DOB _____ SSN _____

Statement of Financial Responsibility

I understand that payment for services, whether cosmetic or not, is solely the responsibility of the patient or their guarantor and as a courtesy Dr. Gawley will bill my insurance. I hereby authorize Dr. Bryan Gawley to bill my insurance company or other third parties responsible for my medical charges. I also authorize Dr. Gawley to release any medical information that may be requested by my insurance company to help with the process of my claims. I authorize and request that payment be made directly to Dr. Bryan Gawley for all medical and surgical services. I understand that I am responsible for any balance not covered by my insurance company.

Signature of patient/responsible party/legal guardian

Relationship to patient

Date