

Gawley Plastic Surgery, Inc.
Bryan W. Gawley, M.D.
7970 E. Thompson Peak Parkway, Suite 101
Scottsdale, Arizona 85255

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? _____

IF WE ARE BILLING YOUR INSURANCE COMPANY PLEASE COMPLETE THE FOLLOWING:

Primary Insurance Company: _____ Insurance Phone: _____

Policy#: _____ Group# _____ Employer: _____

Policy Holder's Name _____ DOB: _____ Social Security: _____

Secondary Insurance Company: _____ Insurance Phone: _____

Policy#: _____ Group#: _____ Employer: _____

Policy Holder's Name: _____ DOB: _____ Social Security# _____

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

