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Suite 640
Atlanta, Georgia 30327

Main: (404) 351-0051
Fax (404) 351-0632

Website:
www.pacesplasticsurgery.com

**Which Physician Will
You Be Seeing Today?**

- T. Roderick Hester
- Foad Nahai, MD
- Mark Codner, MD
- Clinton D. McCord, Jr., MD
- Farzad R. Nahai, MD
- Krjstin A. Boehm, MD
- _____

**How Did You Hear About
Paces Plastic Surgery?**

- Internet
- Paces North
- Magazine/Advertisement
- Paces Staff

Name

- Physician

Name

Phone

- Family/Friend

Name

- Hospital/Surgery Center

Name

PATIENT INFORMATION

DATE _____

Patient Name _____

Address _____ Apt Number _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Cell Phone _____ Social Security Number _____

Name of Employer _____

Date of Birth _____ Age _____ Sex M F

Marital Status Single Married Widowed Divorced

Spouse/Parent Name _____ Phone _____

Name of nearest relative **NOT** living with you _____

Phone _____ Relationship _____

MEDICARE PATIENTS MUST COMPLETE THE FOLLOWING: (THIS CAN BE EITHER YOUR FAMILY OR REFERRING PHYSICIAN. **WE CAN NOT FILE YOUR CLAIM WITH OUT THIS INFO.**)

Physician _____

Address _____

Phone _____

Insurance Policy Holder Information (If you have Medicare you are the policy holder.)

Policy Holder Name _____ Relationship _____

SSN _____ Phone _____ DOB _____

Address _____ City,State,Zip _____

****PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST TO PHOTOCOPY**
MEDICARE PATIENTS MUST HAVE YOUR FAMILY PHYSICIAN**

Primary Insurance Company's Name _____

Secondary Insurance Company's Name _____

I hereby consent to treatment of myself, my child or the above named minor, for whom I accept responsibility, the release of medical information to any insurance carrier or direct payment to Paces Plastic Surgery for any treatment or examination rendered is authorized. I hereby acknowledge and accept final responsibility for payment or charges for medical services rendered.

Signature of patient or authorized person

Date

SIGNATURE IS REQUIRED FOR TREATMENT