## Please print legibly and press firmly with ballpoint pen.

## **Dr. Yu Plastic Surgery**

☐ Kenneth Yu				
PATIENT INFORMATION	Patient Name  Last First  Address  Street  Home Phone ()  Employer  Employer Address  Street  Work Phone ()  Social Security #  Name & Phone # of Emergency Contact Person	City State Zip E-mail Driver's License #		
RESPONSIBLE PARTY INFORMATION	Responsible Party Name	City State Zip Relationship to Patient		
INSURANCE INFORMATION		Certificate #		
REFERRING PHYSICIAN	Referring Physician AddressStreet  Also Send Reports To: Physician AddressStreet Physician AddressStreet	City State Zip  Phone #  City State Zip		

**Authorization:** I hereby authorize the physician to furnish information to insurance carriers concerning this illness/accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as valid as the original.

Date	Signature	