NORFOLK PLASTIC SURGERY, P.C. (757) 466-1000

☐ Lawrence B. Colen , M.D., F.A.C.S. (Please Print Legibly & Fill In All Blanks) ☐ Theodore W. Uroskie, Jr., M.D.

Patient's Name ______________________________
Last First Middle

Address ______________________________
Street & Apt # City State Zip

Home Phone __________ Cell Phone __________ Other Phone __________

Any restrictions for contacting you? ❒ No ❒ Yes
Would you like to be included in our e-mail newletter? ❒ No ❒ Yes
E-mail: __________

Contact Restrictions: ______________________________

Age ______ Birthdate ___/___/___ SS# ____-____-____ ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married ❒ Divorced ❒Widowed
Spouse's Name: __________ Wk Ph: __________
Spouse's Employer: __________

Patient's Employer __________ Occupation __________

Work Phone __________ Ext: ______ Is it okay to call you at work? ❒ Yes ❒ No

Address ______________________________
Street & Suite # City State Zip

Emergency Contact
(Not in your household) __________ Relationship to Patient __________

Home Phone __________ Work Phone __________ Other Phone __________

Address ______________________________
Street & Apt # City State Zip

Primary Health Insurance Company ______________________________

Policy # __________ Group # __________ Ins. Phone __________

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ ______

Insured's Name: __________ DOB __________ SSN: __________

Secondary Health Insurance Company ______________________________

Policy # __________ Group # __________ Ins. Phone __________

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ ______

Insured's Name: __________ DOB __________ SSN: __________

Referring Physcian: __________ **Phone:** __________

Is this an injury? Y / N **Date/Time of Injury:** __________ **Work Related?** Yes No

Is there an attorney involved? Y / N **Name:** __________ **Phone:** __________

I authorize Dr. Lawrence Colen or Dr. Theodore Uroskie to provide medical treatment to me. I also authorize the release of medical records and/or financial information as necessary for filing insurance claims and the release of records from this practice to any other practioners I may be referred to for further treatment. I understand that it is my responsibility to obtain any necessary referrals required by my insurance company. I authorize direct payment from said insurance to the practice. I agree to pay all insurance co-pays, deductibles, and coinsurnace at the time that services are rendered. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I agree to pay the balance due within 30 days, in the event that insurance denies payment. I agree to be responsible for payment of all charges incurred as well as collection/attorney fees of 33 1/3% and all other related costs of collection, including finance charges, should such action be necessay. A copy of this authorization shall be as valid as the original. I understand that my insurance may require pictures to be submitted to obtain surgery/procedure authorization(s).

Signature ______________________________ **Date** __________