

Prestige Plastic Surgery
Gary A. Vela, M.D., F.A.C.S.

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Patients Name: _____ Sex: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Social Security Number: _____ Birth date: _____

Marital Status: _____ E-mail: _____

Employer: _____ Referred By: _____

Reason for Office Visit: _____

Insurance Information:

Insurance Carrier: _____

Subscriber Name: _____ Birth date: _____

Relation to Subscriber: _____ Specialist Co-Pay: _____

Subscribers Employer: _____

RELEASE AND ASSIGNMENT OF BENEFITS

I assign directly to Prestige Plastic Surgery and/or Gary A. Vela, M.D., F.A.C.S., all insurance benefits, if any, payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I authorize the use/disclosure of my health information to insurance companies for the purposes of obtaining payment for services.

Signature

Date