- 8175 Creekside Dr, Ste 100
  Portage, MI 49024
- 3600 Capital Ave SW, Ste 102
  Battle Creek MI 49015

WEST MICHIGAN
Plastic Surgery

Scott D. Holley, M.D., F.A.C.S.
Office 269.222.1611
Fax 269.222.1607
wmips.com

WELCOME TO OUR OFFICE!

Doctor: _____ **Date:** _____

Patient's Name: First _____ MI _____ Last _____ Maiden _____

Date of Birth _____ Sex ☐ M ☐ F Soc Security No. _____ Marital Status S M W D

Patient Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____
to receive occasional announcements

Patient Employer _____ Employer Address _____

Patient Occupation _____ _____

IF PATIENT IS A MINOR, name of person responsible for account: _____

Relationship _____ Date of Birth _____ Social Security No. _____

Employer _____ Work Phone _____ Home Phone _____

Home Address _____ City _____ State _____ Zip _____

Primary Physician _____ **Referring Physician** _____

Is your visit work related? ☐ Yes ☐ No Date Accident Occurred: _____

Is your visit auto related? ☐ Yes ☐ No Date Accident Occurred: _____

INSURANCE INFORMATION

Primary Insurance Co. _____

Insurance Co. Address _____

_____

Insurance Co. Phone _____

Policy No. _____

Group No. _____

Subscriber Name _____

Subscriber Social Security No. _____

Subscriber Date of Birth _____

Employer _____

Employer Address _____

Secondary Insurance Co. _____

Insurance Co. Address _____

_____

Insurance Co. Phone _____

Policy No. _____

Group No. _____

Subscriber Name _____

Subscriber Social Security No. _____

Subscriber Date of Birth _____

Employer _____

Employer Address _____

EMERGENCY CONTACT INFORMATION

Contact Name #1 _____

Relationship to Patient _____

Home Phone _____

Work Phone _____

Contact Name #2 _____

Relationship to Patient _____

Home Phone _____

Work Phone _____

PLEASE COMPLETE OTHER SIDE ➡

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ASSIGNMENT AND RELEASE

I, the undersigned, hereby authorize the release of any surgical and/or medical information necessary for the processing of insurance benefits payable to myself or West Michigan Plastic Surgery including medical and/or major medical benefits. I am financially responsible to West Michigan Plastic Surgery for services not covered by this assignment. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Signature of Patient or Guardian **Date**

I hereby give my permission to Dr. Scott D. Holley and West Michigan Plastic Surgery to administer treatment and to perform such minor operative procedures as may be deemed necessary in the diagnosis and treatment of my condition.

Signature of Patient or Guardian **Date**

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Scott D. Holley and/or West Michigan Plastic Surgery for any services furnished me by said provider. I authorize any holder of surgical and/or medical information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 or CMS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releases of the information to the insurer or agency shown.

Signature of Patient or Guardian **Date**