O.M. SULIMAN, M.D.
COSMETIC AND PLASTIC SURGERY

WELCOME TO OUR OFFICE!! PLEASE FILL OUT THIS FORM AS COMPLETELY AS POSSIBLE SO THAT WE WILL GET TO KNOW YOU AND BE OF GREATER ASSISTANCE.

PATIENT INFORMATION (Personal)

Name________________________**Date of Birth**_____________**Age**______________________

Single_______Married______Widow____Divorced______

Address____
Street City Zip

Phone________________**Cell #**__________________EMAIL___________________________

Referred by:___________________________Family Doctor_____________________________

Social Security #:____

Closest Relative Not Living with you_______________Relationship________Phone #_______

Patient's Employer________________________Occupation_____________________________

Employer's Address_______________________Telephone #:____________________________

Spouse's First Name:____

Spouse's Employer:________________________Telephone #:__________________________

INSURANCE INFORMATION

Insurance Company____

Policy Holder's Name and Birthdate:____

Medicare______HMO_____PPO______Self Pay_____(Please provide copy of card)

I hereby authorize Dr. Suliman to release any pertinent information necessary for treatment of my condition and or processing insurance claims. I also authorize payment directly to Dr. Suliman for surgical and or medical benefits for services rendered to me. I understand that I am financially responsible for those charges not paid by the insurance company and will pay whatever collection costs are necessary to collect the unpaid amount, including court cost and a reasonable attorney's fee.

Signature of Patient or Guardian:___________________________________Date_________________