

MICHAEL J. LEE, M.D.

SPECIALIZING IN THE ART OF REFINEMENT AND REJUVENATION

Asst. Professor of Clinical Surgery
2010

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PATIENT REGISTRATION

NAME: (MR./MRS./MS./

DR.): _____ DATE: _____

DATE OF BIRTH: _____

SOCIAL SECURITY: _____

ADDRESS: _____

STREET

CITY

STATE

ZIP

SEX: _____ AGE: _____

MARITAL STATUS: _____

TELEPHONE: (please circle preferred method of contact)

(HOME) _____

(WORK) _____

(CELL) _____

OCCUPATION: _____

EMPLOYER: _____

REFERRED BY: _____

PERSON TO CONTACT IN CASE OF EMERGENCY:

Relationship: _____ Telephone: _____

INSURANCE (list all health insurance policies if applicable)

Insurance name: _____

Policy holder: _____

ID # _____

Group #: _____

Policy holder DOB: _____

Policy holder SS#: _____

Insurance name: _____ Policy holder: _____

ID # _____ Group #:

Policy holder DOB: _____

Policy holder SS#: _____

Receipt of notice of privacy practice form

I, _____, hereby acknowledge receipt of the physician's notice of privacy practices form. It provides detailed information on how the practice may use and disclose my confidential information.

I understand the physician has the right to revise his privacy practices and will give a copy of the revised notice when available.

Signature: _____

Date: _____

If you are not the patient, please specify your relationship with the patient: _____

Assignment: I hereby assign my insurance benefits to be paid directly to my physician.

Signature:

Date:

Release: I authorize the release of any medical information necessary to process my medical insurance claims.

Signature:

Date:

I understand that I am responsible for any amounts not covered by my insurance plan. If I do not have a valid insurance card or coverage cannot be verified at the time of my appointment, I understand that I am responsible for payment at the time of service.

Signature:

Date:

I authorize Michael J. Lee, M.D. to take my preoperative and postoperative photographs for the purposes of documentation.

Signature:

Date: