PLASTIC SURGERY ASSOCIATES
LOUIS MORALES, JR. M.D.
RODNEY SCHMELZER, M.D.
LISA MORRIS, M.D.
5089 SOUTH 900 EAST, SUITE 100
SALT LAKE CITY, UT 84117

				TODAY'S DATE
PATIENT'S NAME (First, M, Last)	DATE OF BIRTH	AGE	GENDER	HOME PHONE NUMBER
PATIENT'S ADDRESS	CITY	STATE	ZIP	CELL PHONE NUMBER
SOCIAL SECURITY NUMBER	HOW WERE YOU REFERRED TO US?			EMAIL ADDRESS
PRIMARY CARE PHYSICIAN	ADDRESS			PHONE NUMBER
REASON FOR CONSULTATION			DATE SYMPTOMS FIRST APPEARED	
IF ACCIDENT, PLEASE LIST DATE	TIME	PLACE		
DESCRIBE WHAT HAPPENED				
PERSON RESPONSIBLE FOR ACCOUNT (Guardian)	DATE OF BIRTH	SOCIAL SECURITY NUMBER		
ADDRESS (If different from above)	CITY	STATE	ZIP	PHONE NUMBER
EMPLOYER	ADDRESS			WORK PHONE NUMBER
SPOUSE OF RESPONSIBLE PARTY	DATE OF BIRTH	SOCIAL SECURITY NUMBER		
SPOUSE EMPLOYER	ADDRESS			WORK PHONE NUMBER
IN CASE OF EMERGENCY (not living with patient)	RELATIONSHIP TO PATIENT	ADDRESS		PHONE NUMBER
PRIMARY INSURANCE COMPANY	INSURED'S NAME		POLICY NUMBER/GROUP NUMBER	
INSURANCE ADDRESS	CITY	STATE	ZIP	INSURANCE PHONE NUMBER
DO YOU HAVE OTHER INSURANCE COVERAGE?	YES NO	(if yes, please complete)		
SECONDARY INSURANCE COMPANY	INSURED'S NAME		POLICY NUMBER/GROUP NUMBER	
INSURANCE ADDRESS	CITY	STATE	ZIP	INSURANCE PHONE NUMBER

I hereby authorize Dr. Louis Morales, Jr. / Dr. Rodney Schmelzer to release to my insurance carrier any medical information necessary to secure payment. I authorize benefits to be made payable directly to Dr. Louis Morales, Jr. / Dr. Rodney Schmelzer. I understand that I am financially responsible to the physician for charges not covered by my insurance policy. I certify that all information given on the patient information sheet is complete and correct to the best of my knowledge. In the even of default of payment of charges, the responsible party agrees to pay collections fees including reasonable attorney fees. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as an original.

I hereby give permission to Dr. Louis Morales, Jr. / Dr. Rodney Schmelzer to render treatment as he sees fit upon myself, my son or daughter or anyone else I have guardianship over, and to call any consultant or anesthesiologist, laboratory personnel, etc. as he deems advisable in the care of this case. I also agree to be responsible for their charges, as well as the surgeon's, hospitals, or surgical center's charges. I also give them permission to take and use, as they deem proper, photographs, pertinent to this case. I am advised that though good results are expected, they cannot be and are not guaranteed, nor is there any guarantee against untoward results.

Signature _______________________ Date _______________________