

Kevin B. Mayfield, M.D., F.A.C.S.
8230 Beckett Park Dr., Suite B
West Chester, OH 45069

Please print legibly • All fields are required • This information is used only to communicate with you and/or to file insurance claims.

Reason for your visit _____ How did you hear about us? _____

PATIENT	RESPONSIBLE GUARANTOR	SPOUSE OR NEAREST RELATIVE
Name _____	Name _____	Name _____
Birth date _____	Birth date _____	Birth date _____
Marital Status _____	Relationship to Patient _____	Relationship to Patient _____
Address _____	Address _____	Address _____
City/State _____	City/State _____	City/State _____
ZIP _____	ZIP _____	ZIP _____
SSN _____	SSN _____	SSN _____
Driver's license # _____	Driver's license # _____	Driver's license # _____
Home phone _____	Home phone _____	Home phone _____
Cell phone _____	Cell phone _____	Cell phone _____
Email address _____	Email address _____	Email address _____
Employer _____	Employer _____	Employer _____
Address _____	Address _____	Address _____
City/State _____	City/State _____	City/State _____
ZIP _____	ZIP _____	ZIP _____
Occupation _____	Occupation _____	Occupation _____
Work phone _____	Work phone _____	Work phone _____

INSURANCE INFORMATION

<u>PRIMARY</u>	<u>SECONDARY</u>	<u>TERTIARY</u>
Company _____	Company _____	Company _____
Address _____	Address _____	Address _____
City/State _____	City/State _____	City/State _____
Zip _____	Zip _____	Zip _____
Phone _____	Phone _____	Phone _____
ID # _____	ID # _____	ID # _____
Group # _____	Group # _____	Group # _____
Name of Insured _____	Name of Insured _____	Name of Insured _____
Relationship to patient (circle): spouse parent self	Relationship to patient (circle): spouse parent self	Relationship to patient (circle): spouse parent self

Authorization to release medical information to file insurance and allow direct insurance payment to the doctor:

I hereby authorize Dr. Mayfield to release any information regarding services rendered by him, and to allow a photocopy of my signature be used, to file insurance claims for me.

I also hereby authorize and direct payment checks or electronic fund transfers, for benefits due me for the services rendered by Dr. Mayfield, to be made directly to him. Regardless of my insurance benefits, if any, I understand that Dr. Mayfield is providing medical services to me, and that I am ultimately financially responsible for the fees for the services rendered. I also understand that I am responsible for payment of any co-payments and/or deductible payments prior to services being rendered and/or surgeries being performed. *I have read and signed the office Financial Policy. I understand and agree to the financial policies as outlined by Kevin Mayfield Plastic Surgery LLC.*

X _____
Patient (parent or guardian, if minor) or P.O.A.

Date