METAMORPHOSIS
PLASTIC SURGERY
Your Transformation Starts Here

Daniel P. Markmann, M.D.

Date: _____

Patient's Name _____
(Last) (First) (M.I.)

Responsible Party: (If patient is minor) _____

Street Address (Do Not Use P.O.Box)_____

City_____ State_____ Zip Code_____

Soc. Sec. # _____ Marital Status __S __M (Spouse's Name_____) __Sep __D __W

Date of Birth _____ Sex: ___Male ___Female Race_____

Home Telephone (_____) _____ Work Telephone (_____) _____
please circle one - OK to call or DO NOT call **please circle one - OK to call or DO NOT call**

Cell Phone (____)_____ E-Mail Address _____

Patient's Employer _____ Occupation_____ ___ FT ___ PT ___ Retired

Work Address_____City_____ ST_____ Zip_____

Emergency Contact _____ Home Phone (_____)_____

Relationship to Patient _____ Work Phone (_____)_____

PHOTOS: Dr. Markmann takes pre and post operative photographs of all his patients. These photos are required for your medical record. Photographs may also be taken during your surgical procedure as deemed appropriate by Dr. Markmann. Occasionally, we ask a patient for permission to use their photos for other purposes such as medical journals, magazines, the internet, or our patient photos on display in the office. Your photos will not be used without your knowledge and consent and your name will not be associated with the photos. You will be asked to sign a separate consent form to give us permission to use your photographs.

FINANCING: Cosmetic surgery is not covered by insurance. Financing plans with low monthly payments are available. If interested in financing your surgery, brochures are available in the waiting room or ask our patient coordinator for details. We can also arrange for someone to call you to discuss financing options

INSURANCE ASSIGNMENT I, the undersigned, have insurance with _____. I assign all medical benefits be paid directly to Daniel P. Markmann, M.D. for services rendered. I am financially responsible for all co-pays and deductibles or all fees for services rendered if the insurance company denies benefits. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

PAYMENT GUARANTEE I understand that I am financially responsible for all fees associated with my care as well as any accrued interest, attorney fees and collection costs if the account is turned over for collection.

I understand all of the above and all the information given by me is accurate to the best of my knowledge.

_____ _____
SIGNATURE OF PATIENT/PARENT/GUARDIAN DATE

_____ _____
WITNESS DATE