Advanced Concepts in Plastic Surgery

Experienced, personalized care for beautiful results • SURESH KONERU, MD

Patient's Name:____ Birthdate:____________________________

Address: ____ Phone:________________________

City: ___________________________________ Zip Code:___________________________________

E-mail:______________________________ Last 4 digits of your SSN___________________

Marital Status: Married Single Divorced Widowed Occupation:________________

Primary Doctor:_____________________ who has referred you? ____________________________

Guarantor's Name:____ Last 4 digits of SSN______________

Address:____ Phone:______________________

City:____ Zip Code:____________________

Employer:____________________ Birthdate:_____________________ Relationship:_______

Primary Insurance:____

Address:_________________________________ Phone:______________________

Policy#____ Group#_______________________

Secondary Insurance ____

Address:____Phone:_______________________

City/Sate:____ Zip Code:____________________

Policy#____ Group#______________________

I the undersigned, assign, transfer and set over to Suresh Koneru, M.D. all of my rights, title and interest to my medical reimbursement benefits under my insurance policy above. I understand that I am financially responsible for all charges whether or not paid by my insurance company. I hereby authorize Dr. Suresh Koneru to release any information necessary to secure the payment of benefits and to aid in my treatment. If there is a balance due I will receive three (3) statements and if I do not respond or send payment my account will be sent to collections. If surgery is required all prior balances due will need to be paid two (2) weeks before surgery date. I understand that in connection with the medical services, photographs of the involved area(s) will be taken. Such photographs and information relating to my case may be confidentially published in professional journals or medical books, or used for any other purpose that Dr. Suresh Koneru may deem proper in the interest of medical education, knowledge, or research.

Patient or Guardian: ____Date:_____________