



**ARMANDO J. ALFARO, M.D., FACS**

**PLASTIC & RECONSTRUCTIVE SURGERY**

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**PATIENT INFORMATION**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_ Sex: M F

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Best Number to contact you:            Home            Cell            Work

Email address: \_\_\_\_\_

Marital Status:    Single    Married    Divorced    Widowed    Separated

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

How were you referred? Yellow Pages: \_\_\_\_\_ Internet: \_\_\_\_\_ Dr. Alfaro's Website: \_\_\_\_\_

Friend: \_\_\_\_\_ Physician/ Name: \_\_\_\_\_ Other: \_\_\_\_\_

Reason for Consultation: \_\_\_\_\_

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**INSURANCE INFORMATION**

Primary Insurance Name: \_\_\_\_\_ Secondary Insurance Name: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Date of Birth: \_\_\_\_\_ SS Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Subscriber ID Number: \_\_\_\_\_ Subscriber ID Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

WHEN REGISTERING, PLEASE PRESENT YOUR INSURANCE CARD(S)

CO-PAYMENT IS EXPECTED AT TIME OF SERVICE

**EXPLANATION OF PAYMENT POLICY AND INSURANCE FILING PROCEDURE**

I HEREBY AUTHORIZE ARMANDO J ALFARO JR MD PC TO FURNISH ALL INFORMATION NECESSARY INCLUDING PHOTOGRAPHS TO PROCESS ANY CLAIMS TO ALL OF MY INSURANCE CARRIERS, AND TO ACT ON MY BEHALF REGARDING INSURANCE APPEALS.

I AUTHORIZE PAYMENT OF ALL MEDICAL BENEFITS TO ARMANDO J ALFARO JR MD PC AND UNDERSTAND THAT I AM RESPONSIBLE FOR ALL REMAINING BALANCES NOT COVERED BY THE INSURANCE CARRIERS. SHOULD MY ACCOUNT BECOME DELINQUENT, I AGREE TO PAY INTEREST ON THE OUTSTANDING BALANCE OWED AT THE MAXIMUM AMOUNT PERMITTED BY LAW. IF IT BECOMES NECESSARY TO TAKE ENFORCEMENT TO COLLECT ANY AMOUNT DUE, PATIENT SHALL BE RESPONSIBLE FOR ALL ATTORNEY'S FEE AND COURT COSTS.

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

**HIPPA PRIVACY PRACTICES NOTIFICATION**

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN PROVIDED WITH THE OFFICE NOTICE OF PRIVACY PRACTICES AND THAT I HAVE READ AND FULLY UNDERSTAND THE NOTICE. I HAVE BEEN PROVIDED THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE NOTICE AND MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

**PATIENT PHOTOGRAPHIC AUTHORIZATION**

I CONSENT TO THE TAKING OF PHOTOGRAPHS OF ME OR PARTS OF MY BODY IN CONNECTION WITH PLASTIC SURGICAL PROCEDURES PERFORMED BY DR. ALFARO. I UNDERSTAND THAT SUCH PHOTOGRAPHS MAY BE USED FOR MEDICAL, AND PROFESSIONAL ACTIVITIES INCLUDING THE INTERNET TO PROVIDE INFORMATION AND EDUCATIONAL MATERIALS TO THE MEDICAL PROFESSION AND THE GENERAL PUBLIC. I FURTHER UNDERSTAND THAT MY NAME WILL NOT BE USED AND THAT MY IDENTITY WILL BE HIDDEN AS MUCH AS IS REASONABLY POSSIBLE. I UNDERSTAND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION AND SUCH REFUSAL WILL HAVE NO EFFECT OF THE MEDICAL TREATMENT I RECEIVE FROM DR. ALFARO.

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name**