CARLO P. HONRADO MD, FACS
BOARD CERTIFIED FACIAL PLASTIC SURGEON

Name: _____ **Date of Birth:**____/____/____ **Age:** _____
Last First Middle Mo Day Yr

□ Male □ Female Marital Status:_____ Name of Spouse: _____

If Minor, Name of Parent or Responsible Party: _____

Address: _____ **Apt No:** _____

City: _____ **State:** _____ **Zip:** _____

Social Security No: _____ **Occupation:** _____

Driver's License: _____ **Employer:** _____

Telephone: Home: _____ Work: _____

Cell: _____ Email: _____

Insurance Company: _____ **I.D. Number:** _____

Insured Name: _____ **Insured Date of Birth**: _____/_____/_____
Mo Day Yr

Whom shall we thank for referring you? _____

Personal Physician: _____ **Emergency contact:** _____

Telephone: _____ **Telephone:** _____

Relationship: _____

May we send your physician a report of our findings? □ YES □ NO

AUTHOTIZATION:
I authorize the release of medical information to my insurance company: □ YES □ NO

BILLING POLICY: PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED.

The insurance company is hereby authorized to pay all benefits directly to my attending physician.
If special arrangements for payment are needed, they must be made prior to services; please ask for the office manager.

I have read the above policy and understand my financial responsibility.

Signature: _____ **Date:**____/____/_____
Mo Day Yr

T: 310.286.0043 | F: 310.201.9665 | md@DrHonrado.com
DrHonrado.com | 2080 Century Park East, Suite 1700, Los Angeles, CA 90067