TAL T. ROUDNER, M.D., P.A.
PLASTIC AND RECONSTRUCTIVE SURGERY

PATIENT INFORMATION

NAME _____

PHONE (W)_____ PHONE (H)_____ PHONE (Cell)_____

E-MAIL _____

ADDRESS _____

CITY & STATE _____ ZIP CODE _____

SOCIAL SECURITY # _____ SEX _____ AGE _____ BIRTHDATE _____

EMPLOYER _____ PHONE _____

ADDRESS _____

SPOUSE _____ SPOUSE'S CELL PHONE _____

SPOUSE'S EMPLOYER _____ SPOUSE'S WORK PHONE _____

NEXT OF KIN _____ PHONE _____

FAMILY PHYSICIAN _____ PHONE _____

REFERRED BY _____ DATE OF INJURY _____

PLEASE LIST ALLERGIES _____

PLEASE LIST MEDICATIONS _____

_____

INSURANCE INFORMATION #1 _____

INSURANCE INFORMATION #2 _____

POLICY # _____ GROUP # _____

ADDRESS _____

INSURED PARTY _____

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO TAL T. ROUDNER, M.D., P.A. OF THE MEDICAL EXPENSE BENEFITS, OTHERWISE, PAYABLE TO ME. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE PHYSICIAN FOR CHARGES INCURRED AND THAT SUCH PAYMENT IS NOT CONTINGENT ON ANY SETTLEMENT, JUDGMENT OR INSURANCE PAYMENT.

SIGNATURE X _____ DATE _____

550 BILTMORE WAY, SUITE 890
CORAL GABLES, FLORIDA 33134 305/443-3531