LISA J. PETERS, MD, SC

7236 Madison Street, Forest Park, IL 60130 **708-524-1400**

Patient's Name _____ , _____ / _____
Last First Middle Prefers to be called

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ E-mail _____

Work _____ Preferred contact: ❒ Home ❒ Cell ❒ Work ❒ E-mail

Any restrictions for contacting you? ❒ No ❒ Yes If so, what restrictions _____

Age _____ Birthdate ___/___/___ SS# ___-___-_____ Sex ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: _____ ❒ Other: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
Street & Suite # City State Zip

Emergency Contact _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Cell Phone _____

Primary doctor _____ Address _____

Phone _____ Fax _____

How did you hear about Dr. Peters? ❒ ASPS: _____ ❒ Magazine: _____

❒ Care Credit: _____ ❒ Website: _____ ❒ Seminar: _____

❒ Newspaper: _____ ❒ Insurance: _____ ❒ Hospital: _____

❒ Friend/Relative: _____ ❒ Doctor: _____ ❒ Other: _____

If you were referred by a specific person, may we thank them? ❒ Yes ❒ No Name: _ _____

INSURANCE INFORMATION:

Primary Co: _____ Insured Name: _____ DOB: _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ _____

Secondary: _____ Policy # _____ Group # _____

Ins. Phone _____

I understand and agree that (regardless of my insurance policy), I am responsible for the entrie balance on my account, for all professional services provided to the patient (or myself). I also understand that if payments are not made on time, there will be service charges and interest will be added. I have read all the information contained in the financial policy. I certify that , to the best of my knowledge, this information is correct and true. I will notify this office in case of any changes to my health or any above information.

Cancellation or rescheduling of surgery with less than a 30 day notice will result in a penalty of $500 regardless of insurance coverage or cosmetic unless a doctor's excuse is provided._____(initial)

I hereby authorize the release of any medical information necessary to process my claim. I hereby authorize payment directly to the above physician of the surgical and/or medical benefits for her services.

Signature _____ **Date** _____