RADY RAHBAN, M.D.
PLASTIC AND RECONSTRUCTIVE SURGERY

Today's Date: _____

Name _____ **Birthday** ____/____/____ **Age** _____
Last First Middle

Responsible Party (If A Minor) _____

Mailing Address _____

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

Telephone: Home (_____) _____ **Work** (_____) _____ **Cell** (____) _____

Primary Email Address: _____ ☐ *I would like to receive promotions & news via email*

Sex: **M**☐ **F**☐ **Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Preferred method for confirming appointments: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email

Patient employed by _____ Address _____

Occupation _____ Business Phone _____ Social Security #: _____

Spouse or responsible party name _____ Address _____

Occupation _____ Business Phone _____ Social Security #: _____

How did you hear about Dr. Rahban?
- ☐ Internet Search
- ☐ Magazine
- ☐ Social Media
- ☐ Real Self
- ☐ Yelp
- ☐ Other _____
- ☐ Patient _____

Please check all non-surgical procedures that interest you:
- ☐ Botox or Dysport Injections
- ☐ Dermal Fillers (e.g., Restylane, Juvederm)
- ☐ Lip Enhancements
- ☐ CoolSculpting Non-Surgical Fat Reduction
- ☐ Ultherapy Skin Tightening
- ☐ Other _____

PERSONAL PHYSICIAN
Name _____Phone_____Address_____

EMERGENCY CONTACT
Name: _____Phone_____Relationship_____

INSURANCE
Name of Insurance Provider _____Primary Insurer _____
Contract # _____ Group # _____

ASSIGNMENT AND RELEASE
I, the undersigned, have insurance coverage with the company named above.
I assign, directly to Dr. Shahrad Rady Rahban, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, including possible hospitalizations, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions.

_____ _____
Signature of insured or guardian Date

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