GEORGE ORLOFF, M.D.

PLASTIC & RECONSTRUCTIVE SURGERY
HAND SURGERY

Date_________________________ Home Phone_________________ Cell#_________________

Patient____
Last Name First Name Initial

Responsible Party (if a minor)____

Street Address______________________________ E-mail address____________________________________

City____ State___________________ Zip____________

Sex ☐ M ☐ F Age_________ Birthdate________________ ☐S ☐M ☐W ☐D
(Marital Status)

Patient Employed By____

Business Address____

Occupation________________________________ Business Phone___________________________

Spouse (or responsible party) Name_____________________________Birthdate_________________________

Business Name and Address____

Occupation________________________________Business Phone_____________________________________

Patient Social Security #__________________________ CDL #______________________________________

Do you have Medical Insurance? ☐ No ☐ Yes If yes,

Name of Primary Insurer____

Subscriber #________________________________ Group #_________________________________

Name of Secondary Insurer (if any)____

Subscriber #________________________________ Group #_________________________________

In case of emergency, who should be notified?__________________________ Phone_____________________

Referred by____

ASSIGNMENT AND RELEASE

I hereby authorize examination and whatever services deemed necessary by George Orloff, M.D. I, the undersigned, assign directly to Dr. George Orloff, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges 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 my insurance submissions.

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Signature of Patient/Insured/Guardian Date