THE Julian Institute OF PLASTIC SURGERY

Dr. Marc Polecritti, D.O.
PHONE: 352-606-4754 FAX: 352-556-5249

PATIENT INFORMATION

First Name_____ MI_____ Last Name_____

SSN_____ DOB_____ Male____ Female____

Address_____

City_____ State_____ Zip_____

Home ( )_____ Cell ( ) _____

EMAIL_____

MARITAL STATUS: Single_____ Married_____ Widowed_____ Divorced_____ Separated_____

We are now required to collect Race, Ethnicity, and Language. If you prefer not to report that information, you may choose Refused to report/unreported.

(Please check **ONE** in **EACH CATEGORY** that applies)

RACE		ETHNICITY	PREFERRED LANGUAGE	
☐White	☐ More than one	☐Hispanic or Latino	☐English	☐ Hindi
☐Black or African American	☐ Native Hawaiian	☐Not Hispanic or Latino	☐Spanish	☐Vietnamese
☐Asian	☐ Other Pacific Islander	☐Refused to report/ unreported	☐ Refused to report/ unreported	
☐American Indian or Alaskan	☐ Undefined	☐Undefined	☐ Other _____	
☐Refused to Report/ Unreported	☐ Native			

Employer_____ Occupation_____

Emergency Contact:_____ Relationship:_____

Home ( )_____ Work ( )_____ Cell ( )_____

IF PATIENT IS UNDER 18 YEARS OLD, PLEASE COMPLETE PARENT/GUARDIAN SECTION BELOW.

Parent/Guardian name:_____

Address_____ City_____ State_____ Zip_____

Home ( )_____ Work ( )_____ Cell ( )_____

Social security number:_____ D.O.B.:_____ Male___ Female___

Marital status: Single_____ Married_____ Widowed_____ Divorced_____ Separated_____

PHYSICIAN'S RELEASE AND ASSIGNMENTS

I understand that I am responsible for all charges incurred by me, and I agree that in the event this account is referred to collections, to pay all collection expenses, attorney fees and court costs. I authorize staff of THE JULIAN INSTITUTE OF PLASTIC SURGERY to give me reasonable and proper medical care by today's standards in the community.

PATIENT/PARENT/GUARDIAN **SIGNATURE**_____ Date_____

Primary Physician:_____

We would like to thank the person who referred you—please tell us how you heard about Dr. Polecritti.

_____Thank You.