

Date _____

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PATIENT REGISTRATION/INSURANCE INFORMATION

Last Name _____ First Name _____ Initial _____

Address _____ City _____ State _____ Zip _____

Telephone _____ Mobile _____ Work _____

Sex Male Female EMAIL _____ Do you want to receive our newsletter? yes no

Date of Birth _____ SS# _____ Marital Status _____

Spouse _____

In case of emergency contact _____ Phone _____

How did you hear about us? _____

If a physician referred you, please list _____

Employment Information:

Primary Care Physician:

Patient Employer _____

Group Practice Name _____

Street address _____

Address _____

City _____ State _____ Zip _____

City _____ State _____ Zip _____

Phone _____

Phone _____ FAX _____

May we leave a message on home phone yes no

May we leave message on mobile yes no

May we send information to your home address yes no

May we send information via email yes no

Date _____

Insurance Information:

Primary Carrier _____ Self Spouse

Address _____ City _____ State ____ Zip _____

Phone _____

ID# _____ Group# _____

Name of Policy Holder _____

Secondary Carrier _____ Self Spouse

Address _____ City _____ State ____ Zip _____

Phone _____

ID# _____ Group# _____

Name of Policy Holder _____

Are you interested in financing your cosmetic procedure? yes no

I certify that the information given is accurate and correct. I am fully responsible for all the charges not covered by any insurance company. I authorize payment of medical benefits, when applicable, directly to the treating physician(s) and also authorize the release of any medical information necessary to process insurance claims. I further agree that this authorization will cover all medical services rendered until such authorization is revoked by me.

Date _____ Signature _____

Patient, POA, or Parent/Guardian