

WEST LINN PLASTIC SURGERY CENTER

Physicians and Surgeons

Gregory L. Combs, M.D.

Karl O. Wustrack, M.D., P.C.

PATIENT INFORMATION

A. Name _____		SSN # _____ - _____ - _____	
Marital Status (circle) S M D W		Birthdate _____	Age _____ Sex _____ E-Mail _____
Home Address _____		Home Phone () _____ - _____	
Street _____			
City _____	State _____	Zip Code _____	Cell # () _____ - _____
Employer _____		Occupation _____	
Employer Address _____		Work Phone () _____ - _____	
Spouse/Parent _____		SSN# _____ - _____ - _____	
Spouse/Parent Employer _____		Work Phone () _____ - _____	

B. In Case of EMERGENCY:

Person to contact (not living with you) _____ Phone() _____ - _____

Primary Insurance Co. _____ Phone () _____ - _____

Address _____

Name of Insured _____ ID # _____ Group # _____

Secondary Insurance Co. _____ Phone () _____ - _____

Address _____

Name of Insured _____ ID # _____ Group # _____

Worker's Comp/Auto Ins. _____ Phone () _____ - _____

Adjuster: _____ Claim# _____

Date of injury _____ How injury occurred _____

C. Reason for this visit: Cosmetic Injury Job related injury Auto Accident Other

D. Referred by: _____ Primary Care Physician: _____

E. Insurance Authorization (Please read and sign):

I hereby authorize KARL O. WUSTRACK M.D. and/or GREGORY L. COMBS M.D. to furnish information to insurance and Medicare carriers concerning my illness and treatment and I hereby assign to the Physician all benefit payments, basic and major medical services rendered to myself or to my dependents. I understand if I participate in a managed care plan that to receive benefits I must have a valid referral from my Primary Care Physician before being seen by Physician above. If I am seeking care, and no valid referral has been issued, I am responsible for payment of charges related to my care. All collection costs and attorney fees are incurred by patient if not paid as agreed.

Signature _____ Date _____