

**ROBERT W. SHEFFIELD, M.D., F.A.C.S.**  
**ADAM D. LOWENSTEIN, M.D., F.A.C.S.**  
**Plastic Surgery**  
**1110 Coast Village Circle**  
**Santa Barbara, CA 93108**  
**(805) 969-9004**  
**(805) 969-7224 fax**

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PATIENT REGISTRATION

Last Name \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_

Home Address \_\_\_\_\_ Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Cellphone ( ) \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_ EXT \_\_\_\_\_ E mail \_\_\_\_\_

Social Security \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Marital Status: M S D W

EMERGENCY CONTACT(relationship): \_\_\_\_\_ Phone \_\_\_\_\_

Nearest Relative not living with you \_\_\_\_\_ Phone \_\_\_\_\_

Whom may we thank for referring you to this office? \_\_\_\_\_

**INSURANCE INFORMATION**

Insured's Name \_\_\_\_\_ Insured's SS# \_\_\_\_\_

Insurance Company \_\_\_\_\_

Ins. Co. Mailing Address \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

**PATIENT'S AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND CLAIM PAYMENT**

I authorize the release of any medical information necessary to process this claim and I authorize payment of surgical and medical benefits to Dr. Sheffield/ Dr. Lowenstein when applicable. I accept responsibility for fees for medical services rendered.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Pharmacy \_\_\_\_\_ Phone ( ) \_\_\_\_\_ City \_\_\_\_\_