savingfaces

Patient Application Form

Patient Information

Patient's Name _____ Sex Male ☐ Female ☐

Date of Birth _____ Age _____

Address _____

City _____ State _____ Zip _____ Country _____

Parents' Information

Mother's Name

Address _____

City _____ State _____ Zip _____ Country _____

E-mail _____ Phone _____

Employer Name _____ Yearly Salary _____

Father's Name

Address _____

City _____ State _____ Zip _____ Country _____

E-mail _____ Phone _____

Employer Name _____ Yearly Salary _____

Primary Care Physician

Name _____

Address _____

E-mail _____ Phone _____

savingfaces

Patient Application Form

Insurance Information (Please complete this section if you have medical insurance)

Primary Insurance Carrier_____ Medicaid ☐ Private Insurance ☐

Address_____

Policy # _____

Name of Insured _____ Social Security # _____

Patient Medical Information

Condition: _____

Please tell us about your child's condition and how we can help:

_____

_____

_____

_____

_____

_____

_____

_____

Summary of Treatment / Interventions to Date (include dates of surgery if possible):

_____

_____

_____

_____

_____

_____

_____

Please submit a photo and any available medical records with this application by mail to:

Saving Faces
210 East 68th St, Suite 1f
New York, NY 10065

If you have questions regarding this application, please call (212) 485 – 0616

All Fields Must Be Filled Out. If Any Question Does Not Apply, Write "NA" In That Field Or We Cannot Process The Application.
Saving Faces Is Not Responsible For Healthcare Issues Of Family Members Who Accompany Children.