THE OFFICE OF DR. GEORGE REILLY

Patient Information

			M / F		Single Married Divorced Widowed

Medical Information

	Forehead Lines	"Crow's Feet"	Creases "commas" around mouth or nose	"Marionette" lines	General Volume loss in face

Authorization/Privacy Statement

Insurance Information: This office **DOES NOT** participate in **ANY** insurance plan **including Medicare.** The receptionist will provide you with paperwork at the conclusion of your visit that you can submit to your insurance. Medicare patients can only submit to their secondary insurance. ***PLEASE PROVIDE THE RECEPTIONIST WITH INSURANCE CARDS*** so they can be copied in the event the information is needed for laboratory services.

Authorization/Privacy Statement: I, the undersigned, am responsible for payment. I authorize the release of information to my insurance carrier or referring physician ONLY, and if it should be requested. Otherwise, I understand that it is the policy of this office to release information to NO ONE unless designated by you below. You may list names and phone numbers of family, close friend, or caregiver in the space below, if you elect to.

Signature of Patient/ Parent/Guardian _____ Date:__/__/_____

Name(s) of party that can receive limited information _____

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