Please give us your email and we will keep you updated on specials and promotions in our office!

Email Address____

Your Name____

***** We do not share your email address with anyone else*****

_______ **Yes, I want to receive emails from Dr Goodwin regarding special offers, events, or news.**

_______**No, I do not want to be included in email updates**

Please check interests:

_______**Special Offers** _______**Laser Hair and Scar Removal**

_______**Events** _______**Botox, Juvederm, and other injectables**

_______ **Charity Events** _______**New Services**

_______**Everything! Dr. Goodwin is awesome!**

1411 North Flagler Drive Suite #5000 West Palm Beach Fl 33401 Ph. 561.655.6622 Fax. 561.655.6623

Matthew D. Goodwin M.D.F.A.C.S Plastic Reconstructive and Cosmetic Surgery

Patient Information:

Last Name	First Name	Middle Name
Date of Birth (mm/dd/yy)	Social Security Number	Sex M or F

Billing Address:

Street	City State	Zip

Phone Number:

Home Phone	Work Phone	Cell Phone

Employer Information:

Employer	Occupation	Work Phone #
Street Address	City State	Zip

Insurance Information:

Name of Insurance Company	Policy Number

Other Information:

Who referred you to our Office?

Email Address

1. Payment for services is expected at time of service.
2. If insurance is filed, I authorize benefits to be paid directly to Tenet Florida Physician Services.
3. I am responsible for balances on my account, regardless of insurance coverage. My failure to pay off outstanding balances may result in collection procedures being taken.
4. I authorize the doctor to release any information requested with regard to the processing of my claims.
5. Failure to give 24 hour notice prior to canceling appointments may result in a cancellation fee charge to my account not payable by health insurance.

Patient/Parent's/Guardians Signature	Date

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Matthew D. Goodwin M.D.F.A.C.S Plastic Reconstructive and Cosmetic Surgery

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Last Name ______________________ First Name ______________ Middle

Address ______________________

City ______________________ State __________ Zip

Date of Birth ______________________ Social Security Number

I request and authorize ______________________ to release healthcare information of

the patient named above to:

Matthew D. Goodwin M.D.F.A.C.S
1411 North Flagler Drive, Suite 5000
West Palm Beach, Fl 33401

This request and authorization applies to:

☐ Healthcare information relation to the following treatment, condition and date:

____

☐ All healthcare information ______________________

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL cancroids lymphoranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome) and gonorrhea.

☐ Yes, I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ No, I do not authorize the release of my STD results.

☐ Yes, I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patients Signature ______________________ Date ______________