LOURDES
Plastic & Reconstructive Surgery

7425 Wrigley Dr. Suite 204 | Pasco, WA 99301
PHONE [509] 546-8405 FAX [509] 546-8404
www.lourdeshealth.net

Karen Vaniver MD, FACS
Certified by the American Board of Plastic Surgery
Member American Society of Plastic Surgeons and Aesthetic Plastic Surgeons

Thank you for booking your appointment with Dr.Vaniver! Your comfort and success are our greatest priority. You will experience efficient service with a deep interest in your health and safety. We have also a great passion and desire to complete this journey with you!

New patients are required to complete the following items. Your visit will be more efficient if you complete them before you arrive:

- Patient Registration Form (please complete prior to your visit)
- Medical History Form (please complete prior to your visit)
- Acknowledgement of receipt of Notification of Privacy Practice (you may review our notification of privacy practices on the website)
- Photographic Consent and Consent to Treat and Bill Insurance (in office only)

Please bring your insurance cards and identification with you, even if your interest is cosmetic surgery.

You may wish to arrive 15-30 minutes early if you would like information about any of our services or need assistance completing your Patient Registration Form or Medical History Form. We also have procedural information for you to view that will better help you understand your upcoming procedure.

If you cannot keep your scheduled appointment, we appreciate 24 hr notice, so that we may serve another patient. If you have any questions, please feel free to call us at 509-546-8405.

Yours,

The Staff of Lourdes Plastic and Reconstructive Surgery
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PATIENT REGISTRATION INFORMATION

Patient Name:		DOB:	Age:	☐ F ☐ M
Address:		City:	State:	Zip:
Home Phone:	Work Phone:		Cell Phone:	
Email address:		Occupation:		
Preferred Contact Method:		Employer:		
Social Security No.:		Spouse/Partner Name:		
Referred by:		Spouse/Partner DOB:		
PCP:		Spouse/Partner Employer:		

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Subscriber:	Subscriber:
Relationship to patient:	Relationship to patient:
ID Number:	ID Number:
Group Number:	Group Number:
Does your insurance require a referral for a specialist? ☐ Yes ☐ No	
Does your insurance require pre-authorization for hospitalization or procedures? ☐ Yes ☐ No	
If yes, phone number to call:	

BILLING

If person responsible for billing is other than patient, please complete the following:		
Name:	Social Security No.:	
Relationship to patient:	Employer:	
Address:	City/State:	Zip:
Home phone:	Work phone:	
Email:	Cell phone:	

EMERGENCY CONTACT

Person to contact in case of emergency, not living at the above address:	
Name:	Phone:
Address:	City/State/Zip:

I authorize examination & treatment of the person named above. The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Dr. Karen B. Vaniver. I also authorize Dr. Karen B. Vaniver or her agents to release any medical information acquired in the course of my examination and treatment required to process my claims.

Signature:______________________________ Date:______________________

Print name:______________________________ Relationship to patient:______________

May we have permission to send you information by email? ☐ Yes ☐ No