GENERAL SURGERY ASSOCIATES

REFERRING PHYSICIAN__________________________PRIMARY CARE PHYSICIAN________________________________

PATIENT NAME ______________________________ _____________________________ _____SEX _______ AGE_______
LAST, FIRST M

BIRTHDAY________________________ SSN ___________________________ MARITAL STATUS ________________

RACE ___________________ ETHNICITY ________________________________ LANGUAGE ______________________

HOME PHONE # __________________________________ CELL PHONE # ____

MAILING ADDRESS ____ EMAIL __________________________________
STREET

____ ______________________________ _____________________
CITY STATE ZIP

EMPLOYER ____ OCCUPATION _______________________________________

WORK PHONE # ____ EXT_________________________________

GUARANTOR AND/OR EMERGENCY CONTACT

NAME ____ BIRTHDATE ___________________

RELATION TO PATIENT ____ SSN ___________________________________

ADDRESS ____ PHONE# ___________________________________
STREET

____ ______________________________ _____________________
CITY STATE ZIP

EMPLOYER ____ OCCUPATION ______________________

WORK PHONE # ____ EXT_________________________________

INSURANCE: IS THIS A WORK RELATED INJURY? _____________ IF YES, DATE OF INJURY? ______________

NAME OF PRIMARY INSURANCE ____ PHONE _______________________

CLAIMS ADDRESS ________________________________CITY ____________________ STATE ________ ZIP __________

POLICY HOLDER _________________________________ DATE OF BIRTH ___________ SSN ______________________

RELATIONSHIP TO PATIENT ________________POLICY HOLDER'S EMPLOYER _________________________________

POLICY# ___________________________ GROUP# ______________________________ EFFECTIVE DATE ___________

NAME OF SECONDARY INSURANCE ____ PHONE ____________________

CLAIMS ADDRESS ________________________________CITY ____________________ STATE ________ ZIP __________

POLICY HOLDER _________________________________ DATE OF BIRTH ___________ SSN ______________________

RELATIONSHIP TO PATIENT ________________POLICY HOLDER'S EMPLOYER _________________________________

POLICY# ___________________________ GROUP# ______________________________ EFFECTIVE DATE ___________

The above information is complete and correct. I hereby authorize release of information necessary to file a claim with my insurance company and I assign benefits other wise payable to me to the doctor or group indicated on the claim. All professional services rendered are charged to the patient. The patient is responsible for all fees, regardless of insurance coverage. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due to the doctor. A copy of this signature is as valid as the original. In the event that I do not show for a scheduled appointment without 24 hour notice, I understand and agree that I will be charged a $25.00 fee. I do also understand and agree I will be charged a $50.00 surgery cancellation fee if I do not cancel surgery within 72 business hours of scheduled surgery.

___________________________________ _______________ ____ _____________
PATIENT SIGNATURE DATE GUARANTOR SIGNATURE DATE