GENERAL SURGERY ASSOCIATES

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____

PATIENT DEMOGRAPHICS:

PATIENT NAME: _____, _____ _____
LAST FIRST MI

DATE OF BIRTH: _____ / _____ / _____ AGE:_____ SEX:_____ SOCIAL SECURITY NUMBER: _____- _____ - _____

HOME PHONE NUMBER: _____- _____ - _____ CELL PHONE NUMBER: _____- _____ - _____

EMAIL ADDRESS: _____
PREFERRED PHONE NUMBER HOME ☐ CELL ☐ PREFERRED METHOD OF CONTACT: CALL ☐ TEXT ☐ EMAIL ☐

RACE: _____ ETHNICITY: _____ PREFERRED LANGUAGE_____
MARITAL STATUS (*CIRCLE*): S M W D

MAILING ADDRESS: _____
STREET

_____ _____ _____
CITY STATE ZIP

PARENT/GUARDIAN (*IF APPLICABLE*): _____

EMPLOYER: _____ OCCUPATION: _____

WORK PHONE NUMBER: _____ EXTENSION: _____

EMERGENCY CONTACT:

NAME: _____ RELATION TO PATIENT: _____

BEST CONTACT PHONE NUMBER: _____- _____ - _____

INSURANCE INFORMATION: ***(PLEASE FULLY COMPLETE IN ORDER FOR YOUR INSURANCE TO BE BILLED)***

IS THIS A WORK RELATED INJURY? _____ IF YES, DATE OF INJURY? _____

PRIMARY INSURANCE: _____ PHONE: _____

POLICY HOLDER NAME: _____ DATE OF BIRTH: _____ SSN: _____

RELATIONSHIP TO PATIENT: _____ POLICY HOLDER'S EMPLOYER: _____

POLICY # _____ GROUP # _____ EFFECTIVE DATE: _____

SECONDARY INSURANCE: _____ PHONE: _____

POLICY HOLDER NAME: _____ 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 PARENT/GUARANTOR SIGNATURE DATE