

PATIENT INFORMATION FORM

Please fill out completely

Name of Patient: _____
First Middle Last Date of Birth Sex Marital Status

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work Phone: _____

Social Security Number: _____ Driver's License#: _____ Email: _____

Employer: _____ Occupation: _____

Employment Address: _____ May we contact you at work? (Circle) Yes No

Emergency Contact: Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Who Referred you to our office?

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Care Physician:

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

*****In order to avoid error or delay in the processing of your insurance claim, it is essential that the following section be filled our completely.**

PRIMARY INSURANCE COMPANY

Name: _____

Member ID Number: _____

Group Number: _____ Copay: _____

Name of Insured (employee): _____

Employer: _____

Employer Phone: _____

Insured's Social Security: _____

Insured's Date of Birth: _____

SECONDARY INSURANCE COMPANY

Name: _____

Member ID Number: _____

Group Number: _____ Copay: _____

Name of Insured (employee): _____

Employer: _____

Employer Phone: _____

Insured's Social Security: _____

Insured's Date of Birth: _____

It is my responsibility to pay any copayment, deductible amount, co-insurance or any other balance not paid by my insurance. Finance charges (at an annual rate not to exceed 18%) on unpaid balances will be added to my account after 90 days. If it becomes necessary for my account to be turned over to a collection agency, I understand that collection fees will be added to my balance. I understand I will be responsible to pay all collections fees, attorney fees and court costs.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and other health plans to: **Center of Surgical Specialists, PC**. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information, including medical history and medical records, to my insurance company.

PATIENT SIGNATURE **DATE**

Update: _____