

SurgOne, P.C.

PATIENT INFORMATION

Patient Email Address: _____

Requesting/Referring Physician _____ **Primary Care Physician** _____

Name (Legal): **Last:** _____ **First:** _____ **M.I.** _____ **Mr. Mrs. Ms.** Nickname: _____

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

Sex: M F **Marital Status:** S M W D **SS#:** _____ **Date of Birth:** _____ **Age:** _____
MM DD YYYY

Phone: Home () _____ **Work** () _____ **Cell/Pager** () _____

Patient's Employer: _____ **Patient's Occupation:** _____

Employer's Address: _____ **Employer's Phone #:** _____

Spouse/Guardian Name: _____ **Date of Birth** _____ **SS#** _____
MM DD YYYY

Address (If different from patient): _____ **City:** _____ **State:** _____ **Zip:** _____

Spouse/Guardian Employer: _____ **Employer's Address:** _____

Spouse/Guardian Home Phone: _____ **Work Phone:** _____ **Cell/Pager:** _____

Person Responsible for Payment of Services (If different from Patient): _____

Emergency Contact: Relative/Friend, **not living with you** (In case we are unable to contact you, or need to contact someone regarding your care in an emergency).

Contact: _____ **Phone #:** _____ **Relationship to Patient:** _____

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

Long Term Contact: Relative/Friend, **not living with you** (Should we need to contact you in future years if you have moved from address given in patient info. above).

Contact: _____ **Phone#:** _____ **Relationship to Patient:** _____

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

INSURANCE INFORMATION

Legible Copy of Ins. Card

Copy of Driver's License

PRIMARY Insurance: _____ **Subscriber ID#:** _____

Group# _____ **Mailing Address (for claims):** _____

Policy Holder Name _____ **Relationship:** Self / Spouse / Child / Other _____

DOB: _____ **Phone #:** () _____ **Employer carrying insurance:** _____

Deductible: _____ **Copay:** _____ **If Accident:** WorkComp or Auto: **Date of Injury** _____ **Claim No.** _____

SECONDARY Insurance: _____ **Subscriber ID#:** _____

Group# _____ **Mailing Address (for claims):** _____

Policy Holder Name _____ **Relationship:** Self / Spouse / Child / Other _____

DOB: _____ **Phone #:** () _____ **Employer carrying insurance:** _____

Deductible: _____ **Copay:** _____ **If Accident:** WorkComp or Auto: **Date of Injury** _____ **Claim No.** _____

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES. I WILL FURNISH THIS OFFICE WITH ALL INFORMATION NECESSARY TO BILL MY INSURANCE. ANY BALANCE AFTER INSURANCE HAS PAID OR DENIED IS DUE BY ME. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE REASONABLE COST OF COLLECTION, TO INCLUDE ATTORNEY FEES. I UNDERSTAND THAT MY INSURANCE BENEFITS AND REFERRAL REQUIREMENTS ARE MY RESPONSIBILITY AND THAT ALL COPAYMENTS ARE DUE AT THE TIME OF SERVICE.

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO PHYSICIAN FOR THESE SERVICES AND ALL FUTURE CLAIMS AND I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM AND ALL FUTURE CLAIMS.

X _____ (Signed) Date: _____