

ACCOUNT NUMBER

SURGICAL ASSOCIATES, P.C.

SET-UP DATE

PLEASE PRINT - PRESS DOWN HARD

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

PATIENT'S FULL NAME		LAST	FIRST	MIDDLE	DATE OF BIRTH	AGE
STREET ADDRESS				CITY, STATE, ZIP CODE		
HOME PHONE ()		CELL PHONE ()		E-MAIL ADDRESS		
SOC. SEC. NO.		MARITAL STATUS		SEX		
		<input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
PATIENT'S EMPLOYER		OCCUPATION (INDICATE IF STUDENT)		PART TIME <input type="checkbox"/>	FULL TIME <input type="checkbox"/>	BUSINESS PHONE ()
SPOUSE'S NAME						DATE OF BIRTH
SPOUSE'S EMPLOYER		OCCUPATION (INDICATE IF STUDENT)		PART TIME <input type="checkbox"/>	FULL TIME <input type="checkbox"/>	BUSINESS PHONE ()

RESPONSIBLE PARTY INFORMATION (IF OTHER THAN PATIENT)

NAME OF RESPONSIBLE PARTY		SOC. SEC. NO.	DATE OF BIRTH	HOME PHONE ()
STREET ADDRESS		CITY, STATE, ZIP CODE		RELATIONSHIP TO PATIENT
RESPONSIBLE PARTY'S EMPLOYER		OCCUPATION		BUSINESS PHONE ()
			PART TIME <input type="checkbox"/>	FULL TIME <input type="checkbox"/>

INSURANCE INFORMATION

ARE YOU INSURED UNDER YOUR SPOUSE'S INSURANCE?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	IF YES: NAME OF INSURANCE CO.	CONTRACT NO.	GROUP NO.
IS THIS A WORKMAN'S COMPENSATION CLAIM?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	DATE OF INJURY	WERE YOU INJURED IN A MOTOR VEHICLE ACCIDENT?	DATE OF MOTOR VEHICLE ACCIDENT
				YES <input type="checkbox"/>	NO <input type="checkbox"/>
			STATE		

IN CASE OF EMERGENCY NOTIFY (OTHER THAN RESPONSIBLE PARTY)

NAME	PHONE ()	RELATIONSHIP
STREET ADDRESS	CITY, STATE, ZIP CODE	

 WHOM MAY WE THANK FOR REFERRING YOU? _____
 NAME CITY/STATE

EXPLANATION OF PAYMENT POLICY AND INSURANCE FILING PROCEDURES

I hereby authorize Surgical Associates, P.C. to release all medical and/or related financial information to my insurance carrier(s) or other parties making payment for my medical services, as well as other physicians or medical care entities that request information in conjunction with my care and treatment.

I further authorize the payment of benefits directly to Surgical Associates, P.C. I understand that I am responsible for all charges not paid or covered by insurance and agree to pay any costs of collection including a reasonable attorney's fee.

I authorize treatment, care and testing as provided or recommended by Surgical Associates, P.C.'s physicians and staff.

DATE

SIGNATURE

FOR OFFICE USE ONLY