SurgOne, P.C.

PATIENT INFORMATION

Requesting/Referring Physician________________________**Primary Care Physician**____________________________

Name (Legal): ***Last***:_________________________ ***First***:_____________________ ***M.I.***____ Nickname:__________________

Address:____***City***:__________________ ***State***:_______ ***Zip***:__________

Sex: M / F ***Martial Status***: S / M / W / D ***Date of Birth***: ______ ______ ______ ***Age***:______________

MM DD YYYY

Race: ____________________ ***Ethnicity:*** _______________________ ***Language Spoken at Home*** ________________________

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

Patient's Employer:______________________________***Patient's Occupation***:____

Employer's Address:____Employer's Phone #:__________________

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:__________

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___________

Policy Holder DOB:___________***Ins. Phone #:*** ( )________________***Employer carrying insurance***:_____________________

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___________

Policy Holder DOB:____________________

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 HEREBY ASSIGN MY RIGHT AND AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO SURGONE 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:______________________________