



PATIENT INFORMATION

Even though we will copy your insurance cards, please complete all of the information requested below.

PCP/FAMILY PHYSICIAN: _____ REFERRED BY: _____
Patient's Name: _____ Social Security #: _____
Date of Birth (MM/DD/YY): ____/____/____ Age: _____ Sex: _____ Marital Status: _____ Driver's License: _____
Home Address: _____
Home Phone: () _____ Work Phone: () _____ Other (Cell/Pager) _____
Employer: _____ Work Address: _____
Occupation: _____ Email: _____
IN CASE OF EMERGENCY, NOTIFY: _____ Relationship: _____ Phone(s): () _____

INSURANCE INFORMATION

** If the patient has HMO insurance, a referral from the PCP is required to allow the patient to be seen by our group. If the patient does not have a valid referral at the time of the appointment, we will offer to reschedule the appointment until a referral is obtained or see the patient on a self-pay basis.

Primary Insurance: _____ ID # _____ Group # _____
Subscriber's Name: _____ Subscriber's SS # _____ Subscriber's Date of Birth: ____/____/____
Subscriber's Employer: (Same as above) _____ Work phone: _____
Claims Address: _____
Primary Insurance Phone #: _____ Subscriber's Relation to Patient: _____
Secondary Insurance: _____ ID # _____ Group # _____
Subscriber's Name: _____ Subscriber's SS # _____ Subscriber's Date of Birth: ____/____/____
Subscriber's Employer: (Same as above) _____ Work phone: _____
Claims Address: _____
Secondary Insurance Phone #: _____ Subscriber's Relation to Patient: _____

IS THIS A WORK RELATED INJURY? _____ IF YES, PLEASE PROVIDE FOLLOWING INFORMATION:

Claim Adjustor's Name: _____ Phone: _____ Date of Injury: _____
Claim Number: _____ Contact at Employer: _____ Contact's phone: _____

RESPONSIBLE PARTY INFORMATION (If other than patient)

Guarantor's Name: _____ Guarantor's Social Security #: _____
Guarantor's Date of Birth (MM/DD/YY): ____/____/____ Sex: _____ Marital Status: _____ Driver's License: _____
Home Address: _____
Home Phone: () _____ Work Phone: () _____ Other (Cell/Pager) _____
Employer: _____ Work Address: _____

I, the undersigned, certify that I (or my dependent) have insurance coverage as indicated above and assign directly to Capital Surgeons Group all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the physician to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I hereby acknowledge that I have been presented with a copy of Capital Surgeons Group's Notice of Privacy and Practices.

X
PATIENT SIGNATURE (or GUARDIAN if patient is a minor) RELATIONSHIP DATE