GENERAL SURGICAL ASSOCIATES

PATIENT INFORMATION

Name: Last________________________________ First____________________________ MI ______________________
SSN: ________________________Sex: M / F DOB: _________________________ Age: __________________________
Address: ______________________________________ City: ____
State: ___________ Zip: ______Home Ph: _____________ Mobile Ph: _______________________________________
Employer: ______________________________ Occupation: ____
Emp. Address: ______________________________ Work Ph: _________________ Ext. _______________________
Spouse's Name: _______________________ Marital Status: ______________ Occupation: ____________________
Spouse's Employer: ______________________________________ Phone:_______________________________________
Referring Physician: ______________________________________ Email: ______________________________________
PCP: ____ Preferred Pharmacy: ______________________________

Race: ❑ American Indian or Alaskan Native ❑ Asian ❑ Native Hawaiian or Other Pacific Islander
❑ Black or African American ❑ White ❑ Hispanic ❑ Other Race ❑ Other Pacific Islander
❑ Unreported/ Refused to Report

Ethnicity: ❑ Hispanic or Latin ❑ Not Hispanic ❑ Refused to Report

Preferred Language: ❑ English ❑ Spanish ❑ Russian ❑ Indian ❑ Other

How would you prefer to be contacted? ❑ Cell:_________ ❑ Home:____________ ❑ Email:_________________

Would you like to be WEB enabled? ❑ Yes ❑ No

Email:____

PRIMARY INSURANCE INFORMATION

Name of Insurance Company: ____

GUARANTOR INFORMATION (holder of Insurance policy)

Name: Last: ______________________ First:___________________ MI:___ DOB: ____________________________
Address: ______________________________________ Home Phone: ____
City: ______________________ State:____________ Zip: ____
Relationship to Patient: ______________________________ SSN: ____

SECONDARY INSURANCE INFORMATION

Name of Insurance Company: ____

GUARANTOR INFORMATION (holder of Insurance policy)

Name: Last: ______________________ First:___________________ MI:___ DOB: ____________________________
Address: ______________________________________ Home Phone: ____
City: ______________________ State:____________ Zip: ____
Relationship to Patient: ______________________________ SSN: ____

CONTACT PERSON NOT LIVING WITH YOU

Name: ____ Home Phone: _____________________________________
Address: ____ Other Phone: ___________________________________
Relationship: ______________________________________

ASSIGNMENT OF BENEFITS

I hearby assign payment of medical insurance benefits to Michael A. Cardenas, M.D., Bruce E. Conway, M.D., Brittany B. DeBerry, M.D., Brad W. Gurwitz, M.D., George A. Hsieh, M.D., Joe E. Johnston, M.D., David C. Mullins, M.D., Samuel J. Pangburn, D.O., Rachel C. Reeder, M.D., Douglas W. Robinson, Jr., M.D., Jonathan O. Tramer, M.D., Daniel M. Vargas, M.D., Russell L. Woodard, M.D., or General Surgical Associates, for all services rendered. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Signed_______________________________ Date ____

RELEASE OF MEDICAL INFORMATION

I consent to the release of any medical information necessary to process insurance claims for services rendered.

Signed_______________________________ Date ____