



PATIENT INFORMATION SHEET

DATE \_\_\_\_\_ 20\_\_\_\_

Signatures must be updated annually

REFERRING M.D. \_\_\_\_\_ PRIMARY CARE M.D. \_\_\_\_\_

PATIENT ACCOUNT NUMBER: \_\_\_\_\_

MARRIED  SINGLE  SEPARATED  DIVORCED  WIDOWED

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_  MALE  FEMALE

Address \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ E-Mail \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Employer Phone \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

EMERGENCY CONTACT

Name \_\_\_\_\_ Emp. \_\_\_\_\_

Address \_\_\_\_\_ Emp. Phone \_\_\_\_\_

Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Authorized person(s) to release patient's medical information to: \_\_\_\_\_

PRIMARY INS. COPAY \_\_\_\_\_

Ins. Co. \_\_\_\_\_

Employer Name \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's D.O.B. \_\_\_\_\_

Cert. or I.D. No. \_\_\_\_\_

Group No. \_\_\_\_\_

Pre-Cert. Phone No. \_\_\_\_\_

Coverage Info. Tel. No. \_\_\_\_\_

Hospital \_\_\_\_\_

Lab \_\_\_\_\_

Mail Claims to \_\_\_\_\_

- TYPE
 PPO
 HMO
 INS.
 W/C

SECONDARY INS. COPAY \_\_\_\_\_

Ins. Co. \_\_\_\_\_

Employer Name \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's D.O.B. \_\_\_\_\_

Cert. or I.D. No. \_\_\_\_\_

Group No. \_\_\_\_\_

Pre-Cert. Phone No. \_\_\_\_\_

Coverage Info. Tel. No. \_\_\_\_\_

Hospital \_\_\_\_\_

Lab \_\_\_\_\_

Mail Claims to \_\_\_\_\_

- TYPE
 PPO
 HMO
 INS.
 W/C

I acknowledge the opportunity to review SSC's Notice of Privacy Practices.

AUTHORIZATION FOR TREATMENT: I hereby authorize such examinations, treatments, medications, and minor surgical procedures as may be prescribed by the Surgical Specialists of Charlotte, P.A. physician in charge of my care. AUTHORIZATION TO RELEASE INFORMATION: I authorize the physicians of Surgical Specialists of Charlotte, P.A. to release any information required in the course of my treatment for insurance purposes. AUTHORIZATION OF PAYMENT POLICY: I understand that I am responsible for all medical expenses regardless of insurance coverage and whether or not there is an accident with another party at fault. ASSIGNMENT OF BENEFITS: I authorize payment directly to Surgical Specialists of Charlotte, P.A. for any surgical, medical or Medicare benefits payable to me for services rendered.

Patient's Signature (or Guardian if minor)

Date