GREAT SOUTH BAY SURGICAL ASSOCIATES

PATIENT INFORMATION SHEET

Please complete all information: Today's Date _____

Name: _____ Date of Birth: _____Age: _____ Sex: M / F

Social Security #: _____ Marital Status: _____ Email: _____

Address: _____

Home Telephone #: _____ Alternate Phone #: _____

Referring Doctor: _____Referring Doctor Phone #: _____

Primary Doctor: _____Primary Doctor Phone #: _____

Patient's or Parent's Employer: _____ Work Phone #: _____

Employer Address: _____

Spouse/Parent Name: _____ Date of Birth: _____ Age: _____

Address (if different): _____ Social Security #: _____

Spouse/Parent Employer: _____ Telephone #: _____

Emergency Contact: _____Relationship: _____ Telephone #: _____

Insurance Information: Please submit **ALL** insurance cards to receptionist for photocopying. If you have no insurance, you will be required to pay at the time of service. If your insurance requires a referral and you do not have one, you will be required to pay for the charges incurred.

Medicare Number: _____ **Medicaid Number: _____**

PRIMARY INSURANCE:

Insurance Carrier: _____ Telephone #: _____

Insurance Carrier Address: _____

Insured Name: _____ ID#:_____ Group #: _____

SECONDARY INSURANCE:

Insurance Carrier: _____ Telephone #: _____

Insurance Carrier Address: _____

Insured Name: _____ ID#:_____ Group #: _____

I hereby authorize _____M.D. to furnish information to my insurance carriers concerning my illness and treatments and I hereby assign to the physician(s) all payments for medical services rendered to my dependents or myself.

In the event that the provider's charges are outstanding or I fail to provide the office with the correct insurance information, I understand that I am personally responsible for payment of the provider's charges.

_____ _____

Signature of Patient or Guardian Date