GERIG SURGICAL ASSOCIATES, P.C.

PLEASE PRINT

First Name_____Last _____MI_____

Address_____City_____State_____Zip_____

SSN#_____/_____/_____Date of Birth_____/_____/_____ Sex_____Marital Status_____

Home Phone (_____)_____Cell Phone (_____)_____Preferred Contact (Please circle) Home or Cell

May leave confidential information on voice mail (Please circle) Yes No

Email Address (F*or Patient Portal*) _____

Preferred Contact for Reminders: (Circle all methods that apply) Voice Email Text

Preferred Language (*If other than English*)_____

Race/Ethnicity *(Circle all that apply below)*

Caucasian Black Hispanic Asian Native American Pacific Islander American Indian Native Hawaiian Other Unknown Refused

Patient's Employer_____Work Phone (____) _____Ext._____

Referring Dr. _____ **Family Dr.**_____

First Name *Last Name* *First Name* *Last Name*

Pharmacy Name_____**Location**_____

Nursing Home Name_____ Nursing Home Phone (____) _____

I authorize the release of my medical information/records to the following:

Name	**Relationship**	**Phone**	**Emergency Contact? Yes / No**

INSURANCE INFORMATION

Insurance cards and photo ID must be provided at time of visit.

	Primary Insurance	**Secondary** Insurance
Policy Holder's Name	_____	_____
SSN#	_____/_____/_____	_____/_____/_____
Date of Birth	_____/_____/_____	_____/_____/_____
Relationship to Patient	_____	_____

I hereby authorize Gerig Surgical Associates, P.C. to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physicians all payments for medical services rendered to myself or dependants. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services. If item 12 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. I understand that I am responsible for balances due to deductibles, co-insurance, or non-covered services.

Signature_____**Date**_____