DE LA VINA SURGICENTER

PATIENT INFORMATION

PLEASE USE BLACK INK

Current Employment Status

☐ Full Time ☐ Part Time ☐ Not Employed ☐ Retired

Last Name First Middle

Street Address Apt #

City State Zip

mobile phone home phone

Date of Birth _____ Sex: Male/ Female
Month Day Year Circle One

EMAIL: _____

In case of Emergency, Please Notify:

Relationship to patient:_____ Phone_____

Current Employer

Street Address Suite #

City State Zip

Occupation

Social Security # Drivers License #

Date of Injury: _____

Accident Type: _____

Place of Occurrence: _____

Religious Preference: _____

RESPONSIBLE BILLING PARTY- IF OTHER THAN ABOVE

Last Name First Middle

Street Address Apt #

City State Zip

Home Phone Message Work Phone

Social Security # _____

Date of Birth: _____
Month Day Year

Relationship to Patient: Spouse Guardian Attorney
Parent
(Please circle one)

Employer

Street Address Suite #

City State Zip

WORKERS COMPENSATION INFORMATION

Date of Inury: _____
Month Day Year

Work Comp Carrier

Street Address Suite #

City State Zip

Attention: _____

Phone:_____ Fax:_____

Claim # _____

Employer at time of injury

PRIVATE INSURANCE INFORMATION

Primary Insurance

Insurance Address

City State Zip

ID# Group #

Insurance Phone: (_____)_____

Secondary Insurance

Insurance Address

City State Zip

ID# Group #

Insurance Phone: (_____)_____

As courtesy, we will bill your primary and secondary insurance companies. If you have tertiary insurance coverage, it will be your responsibility to bill the balance to them.

ASSIGNMENT OF BENEFITS

I hereby assign all benefits to which I am entitled to the provider of these services, Cold Springs Medical Surgical Group, and/or other contractors: I authorize any holder of medical information about me to release any information needed to determine these benefits, and authorize said assignee to release all medical information necessary to secure payment. This assignment will remain in effect until revoked by me in writing; a photocopy is to be considered valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance company.

Patient Signature:_____