Surgical Services, PC

Date_____ **Patient ID#:**_____

PATIENT INFORMATION

Social Security Number _____/_____/_____(Providing your SSN is optional . However, for patients with Medicare and/or Medicaid having this information may help us determine eligibility for certain health benefits.)

LAST NAME_____**FIRST NAME**_____**MI:**_____

Street Address: _____

City: _____State: _____Zip:_____Home Phone #: ( )_____

Work #: ( )_____ Cell # ( )_____Preferred daytime phone: ( )_____

Date of Birth: _____/_____/_____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Email address:_____Employer:_____

Do we have permission to leave a message at:

home	□ Yes	□ No
cell	□ Yes	□ No
work	□ Yes	□ No

Gender: □ Male □ Female

Race: Select One
- □ American Indian/Alaska Native
- □ Asian
- □ Native Hawaiian or Pacific Islander
- □ Black/African American
- □ White
- □ Other

Ethnicity: Select One
- □ Hispanic/Latino
- □ Not Hispanic/Latino

Preferred Language: _____

Emergency Contact: _____ Relationship to Patient:_____
(First and Last Name)

Emergency Phone#1: ( )_____ Phone# 2: ( ) _____

Referring Physician: _____ Primary Care Physician:_____

Pharmacy:_____ Phone: _____
(Name, location) (if available)

I do grant permission to Surgical Services, PC to contact any pharmacy prescriber to confirm my medications.

_____ _____
(Signature of Patient or Patient Representative) (Date)

PHI: List below anyone we may disclose your health information to. (ie: spouse, children, relative, etc)

Name: _____ Relationship_____
Name: _____ Relationship_____
Name: _____ Relationship_____
Name: _____ Relationship_____

See reverse side

Medical Insurance Information

(The subscriber is the same person as the policy holder)

**** Please present your insurance(s) cards and photo ID for copying.**

Primary Insurance: _____Subscriber's Name_____

Subscriber's Date of Birth: _____/_____/_____ Relationship to Subscriber: □ Self □ Spouse □ Child □ Other

Co-Pay: $_____ Policy ID #: _____Group #: _____

Secondary Insurance: _____Subscriber's Name_____

Subscriber's Date of Birth: _____/_____/_____ Relationship to Subscriber: □ Self □ Spouse □ Child □ Other

Co-Pay: $_____ Policy ID #: _____Group #: _____

If Medicare is not your primary insurance please list the reason below:

□ patient or spouse is employed □ disability □ other

Is the reason you are being seen today related to a work injury? □ Yes □ No

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Surgical Services, P.C. to release information included in my medical record for the purpose of filing a claim with my insurance company including government insurance and/or Medicare.

I hereby authorize payment of medical benefits to ***Surgical Services, P.C.*** 510 E. Bloomington St., Iowa City, IA 52245-2803

I certify the above information is correct to the best of my knowledge. I also understand that **I am financially responsible** for any part of the bill that is not covered by my insurance company. (If my claim is for Workers' Compensation (injury on the job) I agree to have my employer fill out and return to Surgical Services, P.C., Worker's Compensation forms that I am given so that a copy and my chart can be sent to the appropriate Workers' Compensation insurance carrier in a timely fashion.

Signature of Patient or Patient Representative_____**Date:** _____

If signed by Patient Representative, state authority to act on behalf of Patient_____