

PREMIUM SURGERY CENTER



A Community Care Partner

Patient Information

Name: _____ Phone Number: (_____) _____

Address: _____ Birth date: _____ Age: _____

City: _____ SS#: _____ Sex: M F

State: _____ Zip: _____ Marital Status: Single Married Divorced Widowed

County: _____ Driver's License Number: _____ State: _____

Employer: _____ Occupation: _____

Address: _____ Work Phone: (_____) _____

City: _____ State: _____ Zip: _____

Emergency Contact (Not living in household): _____ Phone: (_____) _____

Spouse, Parent or Legal Guardian Information

(If married enter spouse's information. If patient is a child enter the parent or legal guardian information of person who is signing the bottom of this form.)

Name: _____ Phone Number: (_____) _____

Address: _____ Birth date: _____ Age: _____

City: _____ SS#: _____ Sex: M F

State: _____ Zip: _____ Marital Status: Single Married Divorced Widowed

County: _____ Driver's License Number: _____ State: _____

Employer: _____ Occupation: _____

Address: _____ Work Phone: (_____) _____

City: _____ State: _____ Zip: _____

Insurance Information

(Please present ALL Insurance Cards for Photocopying)

Primary Insurance: _____ Secondary Insurance: _____

Insured's Name: _____ Insured's Name: _____

Insured's Date of Birth: _____ Insured's Date of Birth: _____

Insurance Carrier Phone: (_____) _____ Insurance Carrier Phone: (_____) _____

ID Number: _____ ID Number: _____

Group Number: _____ Group Number: _____

Employer: _____ Employer: _____

Effective Date: _____ Effective Date: _____

Assignment/Release

I, the undersigned, agree that I am financially responsible for all charges, not paid by insurance. I hereby assign, directly to **Premium Surgery Center** all medical benefits, otherwise payable to me. I also authorize the release of medical information information pertinent to my case to any insurance company, physician, adjuster, attorney or accrediting body involved in this case. A photocopy of this assignment shall be considered as effective and valid as the original.

Responsible Party Signature: _____ Date: _____