SOUTHERN SURGICAL ASSOCIATES

Identification

Last Name		Sex	
First Name		Date of Birth	
Middle Name		SSN	

Contact

Street Address		Home Phone	
		Mobile Phone	
Mailing Address		Consent to text	Y N
		Work Phone	
City		Email	
Zip		Contact Preference	

Demographics

Language		Pharmacy	
Race		Address	
Ethnicity	Non-Hispanic/Hispanic/Decline	Phone	
Marital Status		OK to import meds	

Emergency Contact

Name	
Relationship	
Phone	

Primary Insurance ~ Please present the receptionist with your card

Policy Holder *(if other than patient)*		Plan Name	
Name		Policy Information	
Date of Birth		ID/Policy	
SSN		Group	
Relationship		Do you have or expect to have Medicare? Y N	

Secondary Insurance ~ Please present the receptionist with your card

Policy Holder *(if other than patient)*		Plan Name	
Name		Policy Information	
Date of Birth		ID/Policy	
SSN		Group	
Relationship			

Primary Care Physician

Name		Phone	
Address		Did they refer you?	

Additional Information

How did you hear about Southern Surgical? _____

ASSIGNMENT AND RELEASE:

-I hereby assign my insurance benefits to be paid directly to Southern Surgical Associates, PA.

-I understand that I am financially responsible for all non-covered services, copays, deductibles, and/or coinsurance. I authorize and give consent for my provicer to bill me directly for recommended services performed that are not covered under the terms of my health plan.

-I authorize the physician to release any medical information required to process this claim.

-I authorize my providers office to contact me by telephone to remind me of my appointments.

-A fee for no shows may apply.

Signed:_____ Date:_____