COLON-RECTAL SURGERY ASSOCIATES, P.C.
PATIENT INFORMATION FORM

Patient Name: **Age:** **DOB:** **Sex:** **Date:**
Patient Address:

Last 4 digits of SS#

Home Phone: **Work:** **Cell:**

Occupation_____
Patient's Employer_____
Address_____

Spouse or Parent_____Date of Birth_____
Occupation_____Spouse's SS#_____
Spouse or Parent's Employer_____
Address_____

INSURANCE INFORMATION – Please present your insurance cards to the receptionist who will scan them into your patient information screen.

PLEASE NOTE – If your insurance coverage is provided through a spouse or parent's employer, birth date information is required in order to process the insurance claim!

Subscriber_____Date of Birth_____

INSURANCE AUTHORIZATION AND ASSIGNMENT

Medicare Patients – I request that the payment of authorized Medicare & Medigap benefits be made payable to either me or on my behalf to Colon-Rectal Surgery Associates, P.C. for any services furnished to me by my physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare Services and its agents as well as my Medigap insurer, to determine these benefits payable for related services. I also understand that I am financially responsible for any amount not covered by my insurance carrier.

Signature_____Date_____

All Other Insurance – I authorize the release of any medical information necessary to process all claims and I authorize payment of medical benefits to Colon-Rectal Surgery Associates, P.C. for any services rendered by the group. I also understand that I am financially responsible for any amount not covered by my insurance carrier.

Signature_____Date_____