PATIENT'S CONFIDENTIAL INFORMATION

PRINT CLEARLY First MI Last Name used Age Birth Date Sex

NAME _____

Address _____ Zip _____

2nd phone Pts. Soc. Sec. # Marital status

Home Phone (area code) _____

Employer _____ Work phone(area code) _____

Spouse's Name _____ Employer _____

Responsible Party _____

Referred by _____ Family Dr _____

Work related: yes no Injury Date: _____ Last date worked: _____

PAYMENT IS EXPECTED AT TIME OF SERVICE: Provide Credit Card Information

Type of card _____ Card # _____ Expiration Date _____

PRIMARY INSURANCE: Insurance Co. Name _____

Address _____ Phone # _____

Agreement/ID # _____ Group # _____ Plan _____

Subscriber Name _____ SS# _____ DOB _____

SECONDARY INSURANCE: Ins. Co. Name _____ phone # _____

Address _____

Agreement/ _____ Group # _____ Plan _____

Subscriber Name _____ SS# _____ DOB _____

BENEFIT ASSIGNMENT: I hereby assign medical and/or surgical benefits including major medical benefits to which I am entitled, private insurance and any other health plan benefits to Pottstown Surgical Associates. A copy of this assignment may be sent to the hospital if surgery is scheduled. This assignment remains in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not submitted to Insurance. I authorize said assignee to release information necessary to obtain payment.

SIGNATURE AUTHORIZED PERSON _____ DATE _____