

# FILL OUT FORM COMPLETELY.



General Surgical Associates, P.C.

215 East Mansion, Suite 3E • Wright Medical Building  
Marshall, MI 49068  
Phone 269-781-4267 • Fax 269-781-2710

391 South Shore Drive, Suite 111b  
Battle Creek, MI 49015  
Phone 269-753-0640 • Fax 269-753-0643

## WELCOME TO OUR PRACTICE!

Patient #: \_\_\_\_\_ Doctor: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Name: 1st \_\_\_\_\_ Mi \_\_\_\_\_ Last \_\_\_\_\_ Birthdate \_\_\_\_\_

Patient Sex: M F Patient SSN: \_\_\_\_\_ Marital Status: S M W D

Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Patient Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone#: \_\_\_\_\_ Cell Phone#: \_\_\_\_\_ Work Phone#: \_\_\_\_\_

Email Address: \_\_\_\_\_

Patient Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_

Patient Occupation: \_\_\_\_\_ Can you be contacted at work? Yes No

If patient is a minor, person responsible for account:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ D.O.B: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone#: \_\_\_\_\_ Home Phone#: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## Insurance Information

### PRIMARY INSURANCE:

Insurance Co. Name: \_\_\_\_\_ Subscriber name: \_\_\_\_\_

Subscriber SSN: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Employer: \_\_\_\_\_ Subscriber Policy/Contract/ID#: \_\_\_\_\_

Office Visit Copay \$ \_\_\_\_\_ Subscriber Group #: \_\_\_\_\_

### SECONDARY INSURANCE:

Insurance Co. Name: \_\_\_\_\_ Subscriber name: \_\_\_\_\_

Subscriber SSN: \_\_\_\_\_ Subscriber DOB: \_\_\_\_\_

Employer: \_\_\_\_\_ Subscriber Policy/Contract/ID#: \_\_\_\_\_

Office Visit Copay \$ \_\_\_\_\_ Subscriber Group #: \_\_\_\_\_

**PRIMARY CARE PHYSICIAN:** \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Cardiologist: \_\_\_\_\_ Is your visit work related? Y N

Must bring billing authorization to appointment. If yes, Date Accident Occurred: \_\_\_\_\_

1. Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Home Ph #: \_\_\_\_\_ Work Ph #: \_\_\_\_\_ Cell Ph #: \_\_\_\_\_

2. Emergency Contact (not at same residence): \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Home Ph #: \_\_\_\_\_ Work Ph #: \_\_\_\_\_ Cell Ph #: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS:**

I, the undersigned, or responsible party hereby assign and authorize payment made directly to General Surgical Associates, P.C., of all my covered health insurance benefits, including but not limited to Medicare, Medicaid, Commercial, all Third Party Payers, HMO and/or Private Managed Care Plans. **I understand my health insurance plan may not cover part or all of the medical services rendered. I fully understand that I am responsible for and agree to pay any and all charges not paid by my health insurance plan or payers.** My assignment of benefits covers all services now rendered and to be rendered in the future until this assignment is revoked in writing. A copy of this assignment shall be considered valid as the original.

**AUTHORIZATION TO RELEASE INFORMATION:**

I authorize the release of any and/or all medical or other information to the Health Care Financing Administration, my insurance carrier(s) other medical providers identified for continuation of care, or other entities necessary to determine insurance benefits, disability benefits or the benefits payable for related medical services and/or supplies provided to me by General Surgical Associates, P.C., and all of its physicians. A copy of this authorization shall serve as an original and forwarded upon request to my insurance carrier(s) and/or the Health Care Financing Administration. This shall serve as my signature on file for claims processing of insurance benefits and release of medical information.

**CERTIFICATION:**

I certify that I am the patient and/or I am the authorized **LEGAL** representative/guardian able to sign and consent on behalf of the patient and/or that I am over 18 years of age.

**CONSENT:**

I hereby give consent/permission to General Surgical Associates, P.C., and its physicians to perform any/all examinations required for treatment/completion of any/all evaluation and management service(s) for today's visit and future evaluation and management service(s). This consent will remain in effect until revoked in writing by me or my legal representative.

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Signature of Patient or Legal Representative

Date

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Witness Signature

Date

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