ROOSEVELT SURGICAL ASSOCIATES, INC. **ACCOUNT #** ____________________

*********Please fill in all blanks. Once completed, please turn over and read and sign our office policy.**********

PATIENT: *(MR. MRS. MS.)* **FIRST NAME** ________________ **MIDDLE** ________ **LAST** ____________________

SEX: Male _____ Female _____ **DATE OF BIRTH** ___-___-____ **AGE** _____ **SOCIAL SECURITY #** _______-______-_______

ADDRESS ______________________________ **CITY** ____________________ **STATE** ______ **ZIP** ____________

HOME PHONE # (___) __________ **CELL ( )** ______________ **MARITAL STATUS:** *M*☐ *S*☐ *D*☐ *W*☐ *LS*☐

EMPLOYER ______________________________ **PHONE** ______________________________

STUDENT: *FULL TIME* _______ *PART TIME* ______ *NAME OF SCHOOL* ______________________________

DRUG ALLERGIES: ____

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WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT IF NOT ABOVE: *SPOUSE* *PARENT* *OTHER*

NAME ______________________________ *SOCIAL SECURITY #* ________-______-______ *BIRTHDATE* ______________

ADDRESS ______________________________ *HOME PHONE (   )* ____________ *CELL(   )* ____________

EMPLOYER ____________________ *ADDRESS* ____________________ *PHONE* ____________________

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INSURANCE INFORMATION:

PRIMARY INS: ______________________ *ID NO:* ______________________ *GP NO:* ________________

SUBSCRIBER NAME ____________________ *SUBSCRIBER DOB* ____________ *EMPLOYER:* ________________

SECONDARY INS. ______________________ *ID NO:* ______________________ *GP NO:* ________________

SUBSCRIBER NAME ____________________ *SUBSCRIBER DOB* ____________ *EMPLOYER:* ________________

IF ANY ADDITIONAL INSURANCE, PLEASE INFORM RECEPTIONIST

☐ **JOB RELATED INJURY?** *DATE OF INJURY* ___/___/____ *W/C CLAIM NO:* ____________________

☐ **ACCIDENT/AUTO ACCIDENT** ****IF YES, NOTIFY RECEPTIONIST OF ALL INFORMATION******.

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REFERRING DR. ____________________ *ADDRESS* ______________________________ *PHONE* ____________

FAMILY DR. ____________________ *ADDRESS* ______________________________ *PHONE* ____________

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EMERGENCY CONTACTS: ***PLEASE LIST TWO DIFFERENT CONTACTS***

NAME: ______________________________ *PHONE #:* ____________________ *RELATIONSHIP* ____________________

NAME: ______________________________ *PHONE #:* ____________________ *RELATIONSHIP* ____________________

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I request that payment of authorized Medicare or other insurance company benefits be made to the above Medical Practice for any services rendered to me by that Physician Group. Regulations pertaining to Medicare assignment of benefits apply. I authorize the above Medical Practice to release to the centers for Medicare and Medicaid Services or any other insurance company any information needed for this insurance claim.

I give permission to proper representative from Roosevelt Surgical Associates to release medical information regarding my medical condition to ____ *YES* *NO*

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I also acknowledge that I have received a copy of Roosevelt Surgical Associates' notice of privacy practices.

SIGNATURE ______________________________ **DATE** ____________ **RELATIONSHIP TO PATIENT** ________________