PRESIDIO
surgical group, pc

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Patient Information Form

Contact Information Appointment Date _____

Name (Last, First, Initial): _____ Birthdate: _____ Male Female

Spouse Name (Last, First, Initial): _____

Local Address: _____ City: _____ State: ___ Zip: _____

Secondary Address: _____ City: _____ State: ___ Zip: _____

Patient or Family e-mail address: _____ Social Security #: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Referred by: _____ Primary Doctor: _____

Marital Status. Please Check One:

Married Single Separated Divorced Widowed

Employment Status. Please Check:

Full Time Part Time Retired Unemployed FT Student PT Student Disabled

Relationship to Responsible party (Guarantor)

Self Spouse Child Other

Primary Card Holder/Spouse Name: _____ Birthdate: _____Policy Holder Employment Status:

Full Time Part Time Retired Unemployed FT Student PT Student Disabled

Patient Employer Name: _____ Phone: _____

Street Address: _____ City: _____ State: ___ Zip: _____

Other Family Employer: _____ Phone: _____

Street Address: _____ City: _____ State: ___ Zip: _____

Address of nearest relative or friend not living with you*

Name: _____ Relation: _____ Phone: _____

Street Address: _____ City: _____ State: ___ Zip: _____

Primary Insurance: _____ Group#: _____ Policy/ID#: _____

Address: _____ Phone: _____

Policyholder's Name: _____ ❑ Male ❑ Female CoPay: _____

Policyholder's Birthdate: _____ Policyholder's Social Security #: _____

Secondary Insurance: _____ Group#: _____ Policy/ID#: _____

Address: _____ Phone: _____

Policyholder's Name: _____ ❑ Male ❑ Female CoPay: _____

Policyholder's Birthdate: _____ Policyholder's Social Security #: _____

Assignment & Release: I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any non-covered services. By signing this, I/We am/are aware that I/We will be charged service charges for any outstanding balance over 30 days old. I also authorize the physician to release any information required to precess this claim. In the event action is brought hereof, the prevailing party shall be entitled to recover fro the other party the court costs and attorney fees determined and awarded by the court. If this account is referred for collection to an Outside Collection Agency, I/We agree to pay collections fees up to 50% of the balance owing. If legal action is deemed necessary, I/We agree to pay reasonable attorney's fees and court costs in addition to the above costs.

Signed: _____ Date: _____