GENERAL SURGERY ASSOCIATES, P.C.

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DR. M.K. GHANTA
DR. PHILIP K. WILES
DR. DANIEL A. BOYETT

PATIENT INFORMATION: PLEASE PRINT

LAST NAME: _____ FIRST NAME: _____ MI: _____

ADDRESS: _____ DATE OF BIRTH: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: (_____) _____ CELL: (_____) _____ CAN WE CALL YOU AT HOME? ❑ YES ❑ NO

SEX: ❑ MALE ❑ FEMALE EMAIL ADDRESS: _____

MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ LEGALLY SEPARATED ❑ DIVORCED ❑ WIDOWED

EMERGENCY LOCAL CONTACT (SOMEONE NOT LIVING WITH YOU) _____

RELATIONSHIP: _____ PHONE: _____ CAN WE LEAVE A MESSAGE? ❑ YES ❑ NO

The following information is required by the Federal Government in order for our office to be in compliance with Title IV American Recovery and Reinvestmanet Act. The information is not needed for your medical assessment and treatment.

PLEASE CIRCLE	**PLEASE CIRCLE**	**Please Give Preferred Language:**
Race: American Indian/Alaska Native, Asian, Black/African American, Native Hawaiian, Other Pacific Islander, White, Multi Cultural, Refuse to Report, Unknown	**Ethnicity:** Hispanic/Latino, Not Hispanic/Non-Latino, Decline, Unknown	_____

SOCIAL SECURITY NUMBER: _____

PATIENT EMPLOYMENT STATUS: (CIRCLE) EMPLOYED / FULL TIME STUDENT / RETIRED / DISABLED

EMPLOYER: _____ PHONE: _____ CAN WE CALL YOU AT WORK ❑ YES ❑ NO

WORK RELATED INJURY ❑ YES ❑ NO IF YES, DATE OF INJURY: _____

REFERRED BY? _____ FAMILY DOCTOR? _____

Referring Physician Name: _____

Referring Physician Address: _____ Phone: _____

SPOUSE'S NAME: _____ WORK #: _____ CAN WE LEAVE A MESSAGE? ❑ YES ❑ NO

IF NAME ON INSURANCE CARD IS OTHER THAN THE PATIENT, PLEASE COMPLETE:

RESPONSIBLE PARTY'S NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ HOME PHONE: _____

SS#: _____ DATE OF BIRTH: _____ EMPLOYER: _____ PHONE: _____

DO YOU HAVE MEDICAL INSURANCE? (CIRCLE) YES / NO

If yes, please give all primary and secondary insurance I.D. cards to the receptionist, along with your Driver's License.

Primary Insurance Name: _____ I.D. # _____ Group # _____

Subscriber's Name: _____ Relationship to Patient: _____

Secondary Insurance Name: _____ I.D. # _____ Group # _____

Subscriber's Name: _____ Relationship to Patient: _____

If Secondary Subscriber is other than Patient, please provide DOB: _____ SS#: _____

AUTHORIZATION & ASSIGNMENT: Please read and sign the following Statement.

I directly assign all medical/surgical benefits to General Surgery Associates, P.C. and understand that I am financially responsible for all charges not covered by insurance. I hereby authorize General Surgery Associates, P.C. to release information for Disability benefits if requested. I hereby authorize the Physician to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

It is customary that payment be made when the service is rendered unless prior arrangements have been made in advance. I understand that I am responsible for any amount not covered by insurance. In the event of non-payment, either by insurance or myself, I agree to pay all cost of collection, including a reasonable attorney's fee in the event it is necessary to employ an attorney to enforce any provision of this contract.

I hereby authorize any physician or hospital to provide copies of my medical history and treatment to General Surgery Associates, P.C. Photocopies of this agreement are as valid as the original.

Signature: **X** _____ Date: **X** _____