

Patient Profile

Date: _____

PATIENT INFORMATION

Name: _____

Address: _____

City,State: _____

Phone: _____ []Home []Work []Other

Phone: _____ []Home []Work []Other

Doctor: _____

Patient ID #: _____ Sex: []M []F

Date of Birth: _____

Social Security #: _____

Marital Status: []Married []Single []Divorced

Referring Physician: _____

Primary Physician: _____

PATIENT EMPLOYMENT

[]Employed []Retired []Unemployed []Other

Phone: _____

Employer: _____

CONTACTS

GUARANTOR

[]Same as Patient

Name: _____

Address: _____

City,State: _____

EMPLOYMENT

Employer: _____

Phone: _____

Phone: _____

Social Security #: _____

Date of Birth: _____

PRIMARY INSURANCE

[]Same as Patient []Same as Guarantor []Other

Insured Party: _____

Insured Phone: _____

Company: _____

Relationship to Primary Insured/Guarantor: _____

Social Security #: _____

Insured ID: _____

Policy Group: _____

Date of Birth: _____

SECONDARY INSURANCE

[]Same as Patient []Same as Guarantor []Other

Insured Party: _____

Insured Phone: _____

Company: _____

Relationship to Primary Insured/Guarantor: _____

Social Security #: _____

Insured ID: _____

Policy Group: _____

Date of Birth: _____

Authorization to Release Information:

I give my permission to Central Carolina Surgery, P.A. to forward records to any other doctor or agency involved in my care. I do hereby consent and authorize Central Carolina Surgery, P.A. to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics, which are part of my medical records.

Authorization to Request Appeal:

I give permission to Central Carolina Surgery, P.A. to initiate an appeal on my behalf to my insurance company(ies) for pre-certification, prior approval, and payment purposes.

Assignment of Benefits:

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to Central Carolina Surgery, P.A. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will remain in effect.

Patient Signature: _____

Dated: ____ / ____ / ____

Guardian/Power of Attorney: _____

Dated: ____ / ____ / ____