ACCOUNT NO. _____ PATIENT INFORMATION:

Name _____
LAST FIRST MIDDLE

Address _____

City _____ State _____ Zip _____

Home Telephone Number: Area Code _____ Number _____

Cellular Telephone Number: Area Code _____ Number _____

Martial Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated

Social Security Number _____

Date of Birth _____ Age _____ Sex MF

Employer's Name _____ Business Phone _____

Employed: ❑ Full-Time ❑ Part Time

Employer's Address _____

Spouse's Name _____ Spouse's Employer _____

Employer's Address _____ Business Phone _____

Student ❑ Full-Time ❑ Part-Time School's Name _____

IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO
b. AUTO ACCIDENT?
YES NO STATE _____
c. OTHER ACCIDENT?
YES NO

PERSON RESPONSIBLE FOR ACCOUNT:

Name _____ Relation _____

Address _____ Telephone _____

Employer's Address _____ Business Telephone _____

INSURANCE INFORMATION:

Primary Insurance _____ Effective date: _____ ID# _____

Address _____ Group# _____

Subscriber's Name _____ SS# _____ Date of Birth _____

Secondary Insurance _____ Effective date: _____ ID# _____

Address _____ Group# _____

Subscriber's Name _____ SS# _____ Date of Birth _____

If Medicare is secondary, why? _____

_____

Person to notify in case of emergency other than spouse _____ Telephone# _____

Family Physician _____

Address _____ Telephone# _____

Name of Physcian who referred you to us _____

Address _____ Telephone# _____

Pharmacy _____ Telephone# _____

Do you smoke? Yes _____ No ____

Are you allergic to any medications? Yes ____ No ____ If so, which ones? _____

_____

MEDICARE & OTHER INSURANCE PATIENTS

I request that payment of authorized Medicare or other insurance bebefits be made wither to me or on my behalf to Surgical Associates of Kingsport, Tnc.for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration or other insurance companies and its agents any information needed to determine these benefits or the benefits payable for related services.

PATIENT'S SIGNATURE: _____

Date: _____