

# EVANSVILLE SURGICAL ASSOCIATES

## PATIENT DATA FORM

DATE: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ PATIENT SS# \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

Last

First

Middle Initial (required)

HOME ADDRESS: \_\_\_\_\_

Street Address

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

City

State

Zip Code

PATIENT'S MARITAL STATUS: S M W D RETIRED: YES \_\_\_ NO \_\_\_ AGE: \_\_\_\_\_ MALE \_\_\_ FEMALE \_\_\_

WORKER'S COMP INJURY: YES \_\_\_ NO \_\_\_ IF YES, DATE OF INJURY: \_\_\_\_\_

IF MINOR, CUSTODIAL PARENT/LEGAL GUARDIAN: NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ PHONE: \_\_\_\_\_ SS# \_\_\_\_\_

SECOND PARENT'S NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ SS# \_\_\_\_\_

PATIENT'S EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

EMPLOYER'S ADDRESS: \_\_\_\_\_ CITY, STATE/ZIP: \_\_\_\_\_

SELF-EMPLOYEED (need name of business and address): \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

Last Name

First Name

ADDRESS: \_\_\_\_\_

City State Zip Code

REFERRING PHYSICIAN: \_\_\_\_\_

Last Name

First Name

ADDRESS: \_\_\_\_\_

City State Zip Code

**PRIMARY INSURANCE POLICYHOLDER:** SELF SPOUSE PARENT OTHER (circle one)

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

Street Address City State Zip Code

**SECONDARY INSURANCE POLICYHOLDER:** SELF SPOUSE PARENT OTHER (circle one)

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

Street Address City State Zip Code

**EMERGENCY CONTACT PERSON (other than household members):**

NAME: \_\_\_\_\_ PHONE #: \_\_\_\_\_

IF YOU WILL BE HAVING A PROCEDURE, IT MAY BE SCHEDULED AT THE EVANSVILLE SURGERY CENTER OR SURGICARE. YOUR PHYSICIAN IS A PART-OWNER OF THE EVANSVILLE SURGERY CENTERS AND SURGICARE. THE PHYSICIAN BELIEVES THE SURGERY CENTER OR SURGICARE IS AN APPROPRIATE SETTING FOR SERVICES FOR WHICH YOU ARE BEING REFERRED. NEVERTHELESS, THE SELECTION OF A SPECIFIC FACILITY ALWAYS RESTS WITH THE PATIENT, AND YOU MAY CHOOSE TO BE REFERRED TO AN ALTERNATE LOCATION IF YOU SO DESIRE.

\_\_\_\_\_  
Patient/Authorized Representative's Signature

DATE: \_\_\_\_\_

### RECORDS RELEASE

I HEREBY AUTHORIZE ANY INFORMATION INCLUDING THE DIAGNOSIS AND RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME TO BE RELEASED TO EVANSVILLE SURGICAL ASSOCIATES, INC.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINTED NAME: \_\_\_\_\_

### CONSENT TO RELEASE INFORMATION

I AUTHORIZE EVANSVILLE SURGICAL ASSOCIATES, INC., TO DISCUSS AND RELEASE MEDICAL INFORMATION REGARDING MY CARE AND SCHEDULED PROCEDURES TO THE FOLLOWING PERSONS/FACILITIES. I MAY WITHDRAW THIS AUTHORIZATION AT ANY TIME WITH WRITTEN NOTICE TO THE OFFICE. AN ADDITIONAL FORM WILL NEED TO BE COMPLETED BY THE PERSONS LISTED BELOW TO REQUEST THE RELEASE OF MEDICAL RECORDS.

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

I HEREBY AUTHORIZE THE PHYSICIAN(S) OF EVANSVILLE SURGICAL ASSOCIATES, INC., TO RELEASE ANY INFORMATION REGARDING SERVICES RENDERED AND ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED TO FILE INSURANCE.

I AUTHORIZE AND DIRECT MY INSURER(S) TO ISSUE PAYMENT CHECK(S) FOR BENEFITS DUE ME FOR THE SERVICES RENDERED BY EVANSVILLE SURGICAL ASSOCIATES, INC. I AM RESPONSIBLE FOR ALL FINANCIAL OBLIGATIONS OF HEALTH SERVICES AND FOR REIMBURSEMENT AND PAYMENT OF CLAIMS FROM MY INSURANCE COMPANY. IF FOR ANY REASON THE ACCOUNT SHOULD BECOME DELIQUENT, I AGREE TO PAY FOR ALL COLLECTION COSTS AND REASONABLE LEGAL FEES.

I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVIII OF THE SOCIAL SECURITY ACTS (IF APPLICABLE) IS CORRECT AND I ASSIGN THE BENEFITS PAYABLE FOR PHYSICIAN SERVICES TO THE PHYSICIAN OR ORGANIZATION FURNISHING THE SERVICE OR AUTHORIZE SUCH PHYSICIAN OR ORGANIZATION TO SUBMIT A CLAIM TO MEDICARE. I REQUEST THAT PAYMENT UNDER THE MEDICAL INSURANCE PROGRAM BE MADE TO THE PHYSICIAN(S) OF EVANSVILLE SURGICAL ASSOCIATES, INC.

I FURTHER CERTIFY THAT I HAVE RECEIVED/REVIEWED A COPY OF EVANSVILLE SURGICAL ASSOCIATES, INC., NOTICE OF PRIVACY PRACTICE AND FINANCIAL POLICY.

\_\_\_\_\_  
SIGNATURE OF PATIENT/SPOUSE/GUARDIAN/PARENT

\_\_\_\_\_  
DATE