

## PATIENT INFORMATION

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

1. PATIENT NAME: \_\_\_\_\_
2. HOME ADDRESS: \_\_\_\_\_
3. CITY & STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_
4. HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_
5. PATIENT'S EMPLOYER: \_\_\_\_\_  
ADDRESS OF EMPLOYMENT: \_\_\_\_\_  
CITY & STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_
6. DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_
7. SOCIAL SECURITY NUMBER: \_\_\_\_\_
8. MARITAL STATUS: \_\_\_\_\_
9. HOW DID YOU HEAR ABOUT OUR OFFICE? MARK ALL THAT APPLY.  
 RADIO     EL PASO, INC.     NEWSPAPER     PHYSICIAN     FRIEND
10. REFERRED BY DOCTOR: \_\_\_\_\_
11. SPOUSE/PARENTS NAME: \_\_\_\_\_
12. EMERGENCY CONTACT: \_\_\_\_\_ TELEPHONE \_\_\_\_\_
13. IS THIS VISIT TODAY WORK RELATED? \_\_\_\_\_ PATIENTS INITIALS: \_\_\_\_\_

## INSURANCE INFORMATION

1. PRIMARY INSURANCE: \_\_\_\_\_  
ADDRESS OF INSURANCE: \_\_\_\_\_  
CITY & STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
TELEPHONE: \_\_\_\_\_
2. GROUP OR POLICY NUMBER: \_\_\_\_\_
3. ID/SOCIAL SECURITY NUMBER: \_\_\_\_\_
4. PERSON INSURED: \_\_\_\_\_
5. THROUGH WHAT COMPANY: \_\_\_\_\_
  
1. SECONDARY INSURANCE: \_\_\_\_\_
2. PERSON INSURED (NAME): \_\_\_\_\_  
ADDRESS OF INSURANCE: \_\_\_\_\_  
CITY & STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
TELEPHONE: \_\_\_\_\_
3. GROUP OR POLICY NUMBER: \_\_\_\_\_
4. ID/SOCIAL SECURITY NUMBER: \_\_\_\_\_
5. PERSON INSURED: \_\_\_\_\_
6. THROUGH WHAT COMPANY: \_\_\_\_\_

## LIFETIME ASSIGNMENT

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO BE MADE DIRECTLY TO EL PASO SURGICAL ASSOCIATES, P.A. FOR SERVICES RENDERED. I ALSO AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

I, THE UNDERSIGNED AGREE THAT IN THE EVENT THAT MY INSURANCE COMPANY OR MEDICARE/MEDICAID DOES NOT COVER THE SERVICES PERFORMED BY EL PASO SURGICAL ASSOCIATES, P.A., I AM RESPONSIBLE FOR THE ENTIRE AMOUNT OF THIS BILL.

SIGNATURE OF PATIENT \_\_\_\_\_ DATE \_\_\_\_\_