MID-MICHIGAN SURGEONS, P.C.

PATIENT LEGAL NAME: ____

ADDRESS: ____
Street City State Zip Code

PHONE: _____________________________/_____________________________/___________________________
Home Work Cell

E-MAIL ADDRESS: ____

BIRTHDATE: ________________ AGE: ________ SS#: ___________________________________

PRIMARY LANGUAGE: _______________________ GENDER: _____ MARITAL STATUS: _______________

RACE (circle appropriate answer): African American American Indian Asian White Hispanic Other

EMPLOYER: ______________________________________ PHONE NUMBER: _________________________

PRIMARY CARE PHYSICIAN: ____________________________ (Must not be left blank)

PHARMACY NAME: _______________________________ PHONE NUMBER: _________________________

IS THIS A WORK-RELATED INJURY: ________ IF WORKER'S COMP, DATE OF INJURY: _________________

CLAIM NUMBER: ______________________________________

PRIMARY INSURANCE: INSURANCE COMPANY: ____

CONTRACT NUMBER: __________________________________ GROUP NUMBER: _______________

SUBSRIBER'S NAME: ___________________________________ DATE OF BIRTH: ________________

SECONDARY INSURANCE: INSURANCE COMPANY: ____

CONTRACT NUMBER: __________________________________ GROUP NUMBER: _______________

SUBSRIBER'S NAME: ___________________________________ DATE OF BIRTH: ________________

EMERGENCY CONTACT PERSON: __________________________________ PHONE: ____________________

NAME OF NEAREST LIVING RELATIVE/FRIEND: ______________________ PHONE ____________________

IF PATIENT IS A MINOR:

MOTHER'S NAME: ____ PHONE: ______________________

FATHER'S NAME: ____ PHONE: ______________________

WE DO BILL AND ACCEPT MOST INSURANCE COMPANIES USUAL AND CUSTOMARY FEES. YOU WILL BE RESPONSIBLE FOR ANY DEDUCTIBLES, COPAYS OR SERVICES NOT PAID BY YOUR INSURANCE COMPANY. IF YOU ARE NOT INSURED, YOU ARE RESPONSIBLE FOR ALL SERVICES RENDERED. PLEASE CONTACT OUR BILLING DEPARTMENT IF YOU HAVE ANY QUESTIONS.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE THAT PAYMENT BE MADE DIRECTLY TO MID-MICHIGAN SURGEONS, P.C., TIN# 38-3413085. A COPY OF THIS SIGNATURE AND STATEMENT SHALL BE AS VALID AS THE ORIGINAL.

____ ______________________________
Patient's Signature or Parent if Minor Date