GALLATIN VALLEY SURGICAL ARTS

PATIENT DEMOGRAPHICS FORM

NAME: (FIRST) (MI) (LAST)

DATE OF BIRTH: AGE: SEX: STATUS: (CIRCLE ONE) S M W D

ADDRESS: CITY: SEX: ZIP CODE:

PHONE#: CELL#: WORK#:

SOCIAL SECURITY NUMBER: EMAIL:

REFERRING PHYSICIAN: EMPLOYER:

HOW DID YOU HEAR ABOUT US?

GUARANTOR OR SPOUSE INFORMATION

NAME: (FIRST) (MI) (LAST)

ADDRESS: CITY: SEX: ZIP CODE:

PHONE#: CELL#: WORK#:

SOCIAL SECURITY NUMBER: EMAIL:

WHO WILL WE BE BILLING FOR YOUR TREATMENT? (CIRCLE ONE) INSURANCE WORKERS COMP SELF PAY

PRIMARY INSURANCE: POLICYHOLDER NAME: POLICYHOLDER DOB:

SECONDARY INSURANCE: POLICYHOLDER NAME: POLICYHOLDER DOB:

Consent to Treat/HIPPA (please initial)

I certify that I have read and fully understand the below statement and consent fully and voluntarily to its contents. (copy of this statement can be obtained from our receptionist)

Signature of Patient or Legal Guardian *Date*

I hereby assign, transfer and sign over to Gallatin Valley Surgical Arts all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. A copy of this signature is as valid as the original.