Suburban Surgical Associates, Ltd. /Suburban Metabolic Institute, LLC

PATIENT DEMOGRAPHICS

WELCOME TO OUR PRACTICE **Today's Date:**

Demographics

*Patient Name:*____ *Cell#*________________ *Home#*_______________

Last name: First Name: Middle Initial

*Address:*______________________________ *City:*______________________ *State:*_______ *Zip Code:*___________

*Date of Birth:*__________ *Race:*__________ ❑ *Hispanic* ❑ *Non Hispanic* *Ethnicity:*__________ *Language:*____________

*Social Security#*__________________________________

Marital Status: ❑ *Single* ❑ *Married* ❑ *Separated* ❑ *Divorced* ❑ *Widowed* *Gender:* ❑ *Male* ❑ *Female*

Are you employed? ❑ *Yes* ❑ *No* ❑ *Disabled* ❑ *Retired*

*Employer Name:*________________________________ *Work Phone:*_______________ *Occupation:*____________________

*Employer Address:*________________________________ *City:*_________________ *State:*_________ *Zip*________

*Emergency Contact:*________________________________ *Home Phone:*_________________ *Work/Cell#*___________

Relationship: ❑ *Spouse* ❑ *Parent* ❑ *Siblings* ❑ *Son/Daughter* ❑ *Friend* ❑ *Other*____________________

*Pharmacy Name:*____________________________ *Pharmacy Phone #*________________________________

PLEASE PROVIDE THE NECESSARY INSURANCE INFORMATION, PROOF OF ADDRESS (EXAMPLE: DRIVER'S LICENSE/ STATE I.D.) PHYSICIANS ORDER, AND REFERRAL (IF NEEDED) TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS

PRIMARY INSURANCE

*Name of Insurance:*____ *Phone Number:*_________________________

*Address:*______________________________ *City:*_______________ *State:*________ *Zip Code:*_____________

*Group I.D. #*_________________ *Policy #*__________________ *Type:* ❑ *HMO* ❑ *PPO* ❑ *OTHER*___________

Relationship to Policy Holder: ❑ *Self* ❑ *Spouse* ❑ *Dependent Child*

*Policy Holder's Name:*_____________________ *Policy Holder Date of Birth*______________ *Social Security #*______________

SECONDARY INSURANCE

*Name of Insurance:*____ *Phone Number:*_________________________

*Address:*______________________________ *City:*_______________ *State:*________ *Zip Code:*_____________

*Group I.D. #*_________________ *Policy #*__________________ *Type:* ❑ *HMO* ❑ *PPO* ❑ *OTHER*___________

Relationship to Policy Holder: ❑ *Self* ❑ *Spouse* ❑ *Dependent Child*

*Policy Holder's Name:*________________________ *Policy Holder Date of Birth*______________ *Social Security #*____________

Primary Care Physician:____ Phone Number:________________________

Address:_____________________________ City:_______________ State:____________ Zip Code________

Referring Physician:____ Phone:______________________________

Address:________________________________ City:_______________ State:____________ Zip Code:________

Insurance Authorization and Assignment:

I authorize the release to Medicare/Other Insurance Company of such information as may be necessary for the completion of my insurance claims. I hereby authorize payment directly to ***Suburban Surgical Associates, Ltd./ Suburban Metabolic Institute, LLC*** of the expense benefits otherwise payable to me. If item 9 of the CMS-1500 claim form is completed, my signature authorizes releasing of the information and payment to the insurer or agency known. I understand that I am financially responsible for the charges made by them for services rendered. I have read this document in it's entirely and I fully understand it.

Signature:____ Date:____________________________