CENTER for MINIMALLY INVASIVE SURGERY

NEW PATIENT INFORMATION

PATIENT NAME: LAST_____FIRST_____ MI____

(PHYSICAL ***AND*** PO BOX IF APPLIES)

ADDRESS_____CITY_____ST_____ZIP_____

HOME PH(_____)_____CELL PH(_____)_____ _WK PH(_____)_____

[ ] I give my permission to receive voice mail messages regarding my healthcare.

BIRTHDAY___/___/_____ AGE_____ Female__ Male__ MARITAL STATUS: single/married/divorced/legally separated/widowed

PREFERRED LANGUAGE: [ ] ENGLISH [ ] OTHER_____ [ ] DECLINED INTERPRETER

IF VETRANS/TRIWEST INSURANCE IS BILLED: SOCIAL SECURITY NUMBER IS REQUIRED: _____/_____/_____ __

PRIMARY INSURANCE NAME_____SUBSCRIBER (CIRCLE) SELF / SPOUSE / CHILD

IF SUBSCRIBER IS NOT YOU: NAME_____**BIRTHDAY**_____/_____/_____ SPOUSE / PARENT

SECONDARY INSURANCE NAME_____SUBSCRIBER (CIRCLE) SELF / SPOUSE / CHILD

IF SUBSCRIBER IS NOT YOU: NAME_____**BIRTHDAY**_____/_____/_____ SPOUSE / PARENT

EMPLOYER_____ADDRESS_____PH(_____)_____

L&I or WORKMANS COMP CLAIM? YES___NO___ DATE OF INJURY ____/____/_____

CLAIM #

CLAIMS MANAGER NAME PH#( )

PRIMARY CARE PHYSICIAN_____PH(_____)_____

WHO REFERRED YOU? (SAME AS ABOVE?)_____PH(_____)_____

(OR DIFFERENT THAN PCP)

EMERGENCY CONTACT_____PH(_____)_____

RELATIONSHIP_____ADDRESS_____

IF THE PATIENT IS A MINOR: PLEASE PRINT:

*PRINT PARENT/GUARDIAN NAME_____PH(_____)_____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. Should my account become delinquent, and CFMIS/ASC undertakes collection efforts to recover any past due amounts, I agree to pay all reasonable costs incurred, including attorney's fees.

I authorize the release of any information pertinent to my case to any insurance company or attorney involved in my case.

I authorize the physician to initiate an appeal or complaint to the insurance commissioner for any reason on my behalf.

I request that payment of authorized insurance benefits be made directly on my behalf to CFMIS/ASC. I authorize any holder of medical information about me to be released to the Healthcare Financing Admin. and it's agents that is needed to determine these benefits or the benefits payable for related services.

*MY SIGNATURE STATES THAT EVERYTHING I HAVE FILLED OUT ABOVE IS TRUE AND ALSO PROVES THAT I HAVE READ AND AGREE WITH THE POLICIES OF THIS OFFICE.

PATIENT or*(GUARDIAN)_____***DATE***_____

SIGNATURE (IF PATIENT IS A MINOR)

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