SURGICAL ASSOCIATES, P.A.

1133 College Avenue, Bldg. E, Suite 220 • Manhattan, KS 66502

David G. Pauls, MD Lance E. Saville, MD Hank B. Doering, MD

PATIENT INFORMATION

Patient Name _____
first middle last

Patient Address _____
street city state zip

Home Phone _____ Cell Phone _____ Married Single Minor

Birth Date _____ Age _____ Sex: M F SS #_____

Email _____ Preferred Pharmacy_____

Race (circle one): Caucasian African American American Indian/Alaska Native Asian Hawaiian/Pacific Islander

Language _____ Ethnicity (circle one): Hispanic Non-Hispanic Refuse to Report

Who referred you to our office? _____ Primary care physician? _____

In case of emergency, we are to notify: _____
name relationship

_____
address city state zip phone number(s)

EMPLOYMENT INFORMATION

Employer _____ Spouse's Name _____

Occupation _____ Spouse's Employer _____

Work Address_____ Spouse's Work Address_____

Work Phone _____ Spouse's Work Phone _____

COMPLETE THIS SECTION IF PATIENT IS A CHILD:

Father's Name _____ Mother's Name _____

SS # _____ SS # _____

Father's Address _____ Mother's Address _____

_____ _____

Father's Employment _____ Mother's Employment _____

Father's Home Phone _____ Mother's Home Phone _____

Father's Work Phone _____ Mother's Work Phone _____

INSURANCE INFORMATION

Primary Insurance _____ Policy Holder _____ DOB _____

Secondary Insurance _____ Policy Holder _____ DOB _____

If covered by Medicare, is the insured retired? Yes No

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment of insurance benefits to Surgical Associates, P.A., for covered physician services and fees. I authorize physicians of Surgical Associates, P.A. to release to my insurance carrier any information necessary to process my claims. A photocopy of this authorization will be considered as valid as the original. I understand I am responsible for payment of all charges not covered by insurance or 60 days past due.

Signature _____ Date _____