

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

Mark R. Wolfe, 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 Transgender SS# _____

Email _____ Preferred Pharmacy _____

Race (circle one):

Caucasian Hispanic African American American Indian/Alaska Native Asian Hawaiian/Pacific Islander Other

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)

Do you have any Advanced Directives? Yes No

Mark all that apply: Do Not Resuscitate (DNR) Living Will Durable Power of Attorney

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 _____