

PATIENT INFORMATION FORM

PATIENT NUMBER \_\_\_\_\_

PERSONAL INFORMATION

Patient's Name \_\_\_\_\_ (last) \_\_\_\_\_ (first) \_\_\_\_\_ (middle)

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex : Male/ Female Marital Status \_\_\_\_\_ Social Security # \_\_\_\_\_

Allergies: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Parent or Legal Guardian if Patient is a minor: \_\_\_\_\_

INSURANCE INFORMATION

Primary Insurance Company Name: \_\_\_\_\_

Policy ID #: \_\_\_\_\_ Policy Group #: \_\_\_\_\_ Subscriber's Name \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Subscriber's Date of Birth \_\_\_\_\_ Subscriber's Social Security # \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

Secondary Insurance Company Name: \_\_\_\_\_

Policy ID #: \_\_\_\_\_ Policy Group #: \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Social Security # \_\_\_\_\_

JOB RELATED INJURY? (Y/N) \_\_\_\_ IF YES, DATE OF INJURY? \_\_\_\_\_ MUST PROVIDE W/C INFORMATION

EMERGENCY INFORMATION

Whom may we contact in the event of an emergency? \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Telephone: \_\_\_\_\_

This information is given for the purpose of establishing an account and medical file with Andover Surgical Associates, Inc. It is understood that I shall be responsible for all charges incurred by me (or any minor child as noted above). I authorize payment for any insurance claims be made directly to the physician.

I have received a copy of the Notice of Privacy Practices for Andover Surgical Associates

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Representative (minor/or unable to sign): \_\_\_\_\_ Date: \_\_\_\_\_

Relationship of Patient Representative to Patient