PRESTON SURGERY CENTER

Personal Information

Last Name: _____ First Name: _____ DOB: _____

Home Phone: _____ Cell: _____ Work: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Sex: Male/Female Marital Status: Single/Married/Widowed/Divorced

Social Security #: _____Employer: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Who is your transportation Home?

Name: _____ Relationship: _____ Phone: _____

Insurance Information

Primary: _____ Policy Holder: _____

SSN: _____ DOB: _____Relationship: _____

Member ID: _____ Group #: _____

Secondary: _____ Policy Holder: _____

SSN: _____ DOB: _____ Relationship: _____

Policy #: _____ Group #: _____

Please sign and return to receptionist (Please read carefully before signing)

I, the undersigned, acknowledge receipt of medical services and authorize the release of any medical information necessary to process this claim for health care payment only. I authorize payment to the provider. I also understand that I should verify coverage with my insurance company as well. I understand that I am financially responsible for all charges whether or not paid by my insurance**. I will also notify Preston Surgery Center of any changes to my insurance and my address/phone**. We will bill your insurance company as a courtesy. However, any balance due is your responsibility. Payment will be requested from you if reimbursement from your insurance company is not received within 60 days.

Name: _____ **Date:** _____