# PATIENT INFORMATION SHEET

Thank you for choosing ASWAD SURGICAL GROUP. Please fill out this form completely. (PLEASE PRINT)

Name: _____ Date of Birth: _____

Address: _____ S.S. # _____-____-_____

_____ Sex: M or F

Home Phone: _____ □ Married □ Single

Cell Phone: _____ □ Divorced □ Widowed

Work Phone: _____ What Pharmacy do you use?

Employer: _____ _____

How did you hear of us? _____ Primary Doctor: _____

## INSURANCE INFORMATION

Primary Ins: □ Medicare □ Medicaid □ Worker's Comp □ BCBS □ Other:_____

Member ID #: _____ Group #: _____

Insured/Card Holder's Name: _____ Relationship:_____

2nd Ins: □ Medicare □ Medicaid □ Worker's Comp □ BCBS □ Other: _____

Member ID #: _____ Group #:_____

Insured/Card Holder's Name: _____ Relationship:_____

** Inform the Registration Desk if this is a Workers' Compensation Claim**

## RESPONSIBLE PARTY (Parent/Spouse/Ins Card Holder)

Name: _____ Date of Birth: _____

Address: _____ S.S. # _____-____-_____

_____ Sex: M or F

Home Phone: _____ Cell #: _____

Employer: _____ Work #: _____

## EMERGENCY CONTACT

Name: _____ Name: _____

Phone #: _____ Phone #: _____

Relationship: _____ Relationship: _____

## INSURANCE AUTHORIZATION AND ASSIGNMENT

I understand my signature authorizes that insurance benefit payments are made directly to Aswad Surgical Group for all medical and/or surgical care. I furthermore authorize Aswad Surgical Group to release any medical information acquired in the course of my treatment to process insurance claims.

Signature:_____ Date:_____

(Patient or Responsible Party)