

DEKALB SURGICAL ASSOCIATES, P.C.
GENERAL SURGERY

DATE _____

Patient's Name _____ Age _____ Date of Birth _____

Address _____ Apt _____ City _____ State _____ Zip _____

Please Check: Married Single Divorced Widow Other Sex: Male Female

Social Security # _____ - _____ - _____ Email Address _____

Home Phone _____ Cell Phone _____

Patient's Employer _____ Occupation _____

Business Address _____ Phone _____ Ext _____

Name of Spouse _____ Spouse's Employer _____

*Emergency Contact _____ Phone _____ Relationship _____
(Some number other than your home phone)

Doctor Who Referred You Here _____ Phone _____

Primary Care Physician _____ Phone _____

Responsible Party Info (If different from patient)

Name _____ DOB _____ Relationship to patient _____

Address _____ City _____ State _____ Zip _____

Social Security # _____ - _____ - _____ Phone Number _____

Primary Insurance Company _____ Phone _____

Policy or ID Number _____ Group Number _____

Policy Holder's Name _____ Policy Holder's Birthdate _____

Policy Holder's Social Security Number _____ - _____ - _____

Secondary Insurance Company _____ Phone _____

Policy or ID Number _____ Group Number _____

Policy Holder's Name _____ Policy Holder's Birthdate _____

Policy Holder's Social Security Number _____ - _____ - _____

Due to pre-certification requirements that are being applied to commercial insurance as well as federally funded plans, it is necessary for us to obtain all insurance information at the time of your first visit to our office. We need to have all insurance information on a signed standard form in our office prior to any surgical procedures performed. Please bring all insurance cards to our receptionist, and she will make photo copies of your cards to assist us in filing your insurance claims and also to use for pre-certification with your insurance company if you require surgery.

In regard to our payment policy, payment is due at the time of your office visit, except for patients on Medicare, Medicaid, HMO's and PPO's (for which we are participating providers). If you are on any of these plans, you will be responsible for any co-payment amounts at the time of your office visit. We will also file insurance claims for these plans when surgery is performed. Any remaining balance or co-insurance amount due after your insurance company pays must be paid within 90 days of your surgery unless special payment arrangements are made with our office.

Signature X _____