General & Laparoscopic Surgical Associates, P.C

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DEMOGRAPHICS REGISTRATION FORM

Please Print

Date ____________________ Home Phone _______________________________ Cell _______________________________

Preferred method of contact:
(to be used for health maintenance & appointment notifications):

- ☐ Email
- ☐ SMS (Text - Cell# must be given)
- ☐ Patient Portal
- ☐ Phone Call (voice reminder)
- ☐ Opt Out

PATIENT INFORMATION

Name ____
Last *First* *Middle Initial*

Address ____ City _______________________ State _____ Zip _________

Birth date __________________________ SS# ______________________________ License# ____________________________

Sex: ❒ Male ❒ Female Age: _______ ❒ Married ❒Single ❒Minor ❒Separated ❒Divorced ❒Widowed

Race __________________ Preferred Language __________________ Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino

Employer/School____Occupation_____________________________

Employer/School Address____ Employer/School Phone_______________________

City ____ State _______ Zip _____________

Email address ____

Emergency Contact ____ Phone ____________________________

Referred By ____________________________________ Primary Care Physician ____________________________________

Pharmacy Preferred ____ City __________________________________

PRIMARY INSURANCE

Was this work related? ______________ If yes, do you have authorization for today's appointment? _____________

If not work related, does your medical insurance require a referral? ________ If yes, did you receive referral? ____________

Person Responsible for Account ____
Last *First* *Middle Initial*

Relation to Patient ________________________________ Birth date _________________ SS# ___________________________

Address _______________________________________ City _________________________ State_____________ Zip_________
(if different than patient's)

Employed By ___________________________________ Occupation _______________________ Phone ___________________

Address _______________________________________ City _________________________ State_____________ Zip_________

Insurance Company____

ID #_____________________________ Group # _________________________ Dates of Coverage ________________________

ADDITIONAL INSURANCE

Is patient covered by additional Insurance? ❒ Yes ❒No

Person Responsible for Account ____
Last *First* *Middle Initial*

Relation to Patient ________________________________ Birth date _________________ SS# ___________________________

Address _______________________________________ City _________________________ State_____________ Zip_________
(if different than patient's)

Employed By ___________________________________ Occupation _______________________ Phone ___________________

Address _______________________________________ City _________________________ State_____________ Zip_________

Insurance Company____

ID #_____________________________ Group # _________________________ Dates of Coverage ________________________

ASSIGNMENT AND RELEASE

Your signature confirms that all of the above information is correct and authorizes General & Laparoscopic Surgical Associates, P.C. to correspond with the physicians above. I authorize the release of information to my insurance company, including Medicare. I also authorize insurance benefits to be paid directly to General & Laparoscopic Surgical Associates, P.C., and a division of Anderson Medical Group . I understand that I am responsible for all deductibles, co-insurance, missed appointment charges, form completion charges, telephone charges when applicable, and non-covered services that may be required. In addition, I agree to pay for any additional charges related to cost of collection in the event I fail to pay my bill. If signed by a guardian or parent, this is also authorization for medical treatment of a minor. A photocopy of this document is to be considered as valid and original.

Signed ____ Date__________________

Witness ____ Date ___________________