



PATIENT INFORMATION

ALLERGIES TO MEDICATIONS:

PLEASE PRINT GENDER: FEMALE MALE MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

NAME: _____ BIRTHDATE: _____

ADDRESS: _____
STREET CITY STATE ZIP

SOCIAL SECURITY NUMBER: _____ EMAIL ADDRESS: _____

PRIMARY CONTACT: HOME # CELL # WORK # MAIL ONLY HOME PHONE: _____ *Ok to leave a message? Y N*

CELL PHONE: _____ *Ok to leave a message? Y N* WORK PHONE: _____ *Ok to leave a message? Y N*

PRIMARY LANGUAGE: English Spanish Other (Please specify): _____ HISPANIC / LATINO: Yes No

RACE: American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White

OCCUPATION: _____ PLACE OF EMPLOYMENT: _____

EMPLOYMENT ADDRESS: _____
STREET CITY STATE ZIP

EMERGENCY CONTACT NAME: _____ PHONE: _____

RELATIONSHIP TO PATIENT: _____

HOW DID YOU HEAR ABOUT US?: Primary Care Physician Specialists Physician Advertisement in Magazine Advertisement in Yellow Pages
 Lifespan Health Connection Hospital Other: Please Specify _____

GUARANTOR INFORMATION

THE INFO. GIVEN BELOW IS WHERE ALL STATEMENTS WILL BE SENT - THIS PERSON IS RESPONSIBLE FOR ALL CHARGES NOT COVERED BY INSURANCE.

PLEASE CHECK IF GUARANTOR IS SAME AS PATIENT

NAME: _____ BIRTHDATE: _____

ADDRESS: _____
STREET CITY STATE ZIP

SOCIAL SECURITY NUMBER: _____ HOME PHONE: _____

PLACE OF EMPLOYMENT: _____ WORK PHONE: _____

EMPLOYMENT ADDRESS: _____
STREET CITY STATE ZIP

PRIMARY CARE PHYSICIAN INFORMATION

NAME: _____ PHONE: _____

ADDRESS: _____
STREET CITY STATE ZIP

REFERRING PHYSICIAN INFORMATION

NAME: _____ PHONE: _____

ADDRESS: _____
STREET CITY STATE ZIP

REASON FOR TODAY'S VISIT: _____

PHARMACY INFORMATION

PHARMACY NAME: _____ PHONE: _____

ADDRESS: _____
STREET CITY STATE ZIP

PLEASE COMPLETE REVERSE SIDE

INSURANCE INFORMATION

IS THIS VISIT WORK RELATED? YES NO AUTHORIZATION NUMBER: _____

PRIMARY INSURANCE

INSURANCE COMPANY NAME: _____

GROUP NUMBER: _____ POLICY NUMBER: _____

POLICYHOLDER NAME: _____ POLICYHOLDER'S SS #: _____

POLICYHOLDER'S BIRTHDATE: _____ RELATIONSHIP TO PATIENT: _____

POLICYHOLDER'S EMPLOYER: _____ CO-PAY: _____

SECONDARY INSURANCE

INSURANCE COMPANY NAME: _____

GROUP NUMBER: _____ POLICY NUMBER: _____

POLICYHOLDER NAME: _____ POLICYHOLDER'S SS #: _____

POLICYHOLDER'S BIRTHDATE: _____ RELATIONSHIP TO PATIENT: _____

POLICYHOLDER'S EMPLOYER: _____ CO-PAY: _____

If Secondary Insurance is Medicare please check the box which indicates your eligibility for the program:

- | | | |
|---|---|--|
| <input type="checkbox"/> 12 Working age beneficiary/spouse with employer group health plan | <input type="checkbox"/> 14 No fault insurance | <input type="checkbox"/> 42 VA |
| <input type="checkbox"/> 13 ESRD beneficiary in the 12 mos coordination period with an employer group health plan | <input type="checkbox"/> 15 Workers Compensation | <input type="checkbox"/> 43 Disabled beneficiary under age 64 with Large Group Health Plan |
| | <input type="checkbox"/> 16 PHS or other Federal Agency | <input type="checkbox"/> 47 Any liability Insurance |
| | <input type="checkbox"/> 41 Black Lung | |

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AUTHORIZATION and RELEASE OF INFORMATION

I am giving USA permission to ask for third party payor/Medicare payments for my medical care. I understand that third party payor/Medicare needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to third party payor/Medicare and the companies that handle third party payor/Medicare payment requests. I understand that the CENTERS FOR MEDICARE/MEDICAID SERVICES (CMS) is the government Medicare agency. I request that payment of authorized third party payor/Medicare benefit be made either to me or on my behalf for any services furnished me by USA, including physician services. I authorize any holder of medical or other information about me to release to the CMS and its agents any information needed to determine these benefits or benefits for related services. I also authorize USA to obtain my medication history from my pharmacy.

Signature

Date

UNIVERSITY SURGICAL ASSOCIATES PATIENT PORTAL

University Surgical Associates patient portal is a secure, confidential, HIPAA compliant communication tool. It is an optional service and you may enroll at any time. The portal is designed to enhance patient-physician communication.

Access to this secure patient portal is an optional service. I may suspend or terminate it at any time for any reason. I acknowledge and fully understand the risks associated with online communication. I acknowledge that using the portal is voluntary and will not impact the quality of care I receive. I agree to adhere to the policies set forth in this agreement. I understand this consent will expire in 12 months and I will be required to sign and update my form. I will notify the office if there is any change in my email address or if I feel my password has been breached. I agree not to hold University Surgical Associates liable for infractions beyond its control. By signing below, I give permission to University Surgical Associates to enroll me in the patient portal.

Signature

Date