CAPITAL HEALTH SURGICAL GROUP

PATIENT INFORMATION

Date: ______________

Patient Name: ______________________________ H. Phone:( ) ____________

Address: ______________________________ Date of Birth: ____________

City: ______________ State: _____ Zip: ________ Soc Sec Number____________

CIRCLE ONE:

Sex: M F **Marital Status:** S M W D Sep **Ethnicity:** Hispanic/Lationo Non-Hispanic/Non-Latino Unknown Declined **Race:** Black/African American White Asian American Indian/Alaska Native Native Hawaiian/Other Pacific Islander Unknown Declined **Language:**____________

Cell Phone ( )______________ E-Mail Address______________

Employer: ______________________________ W. Phone: ( )____________

Work Address: ______________ City: ____________ State: _____ Zip: ________

Pharmacy Name/Phone #______________Spouse/Partner: ______________

Referred by: ______________ Primary Care Physician:______________

Parent/Guardian: (person to be billed if patient is under age 18)

Name: ______________________________ H. Phone ____________

Address: ____

City: ______________ State: ________ ZIP: ____________

Date of Birth: __________ Soc Sec No: ______________

Employer: ______________________________ W. Phone: ( )____________

Work Address: ______________ City: ____________ State: _____ Zip: ________

MEDICAL INSURANCE INFORMATION

Primary Insurance Company: ______________________________Group#:____________

Policy/ID#: ______________ Patient Relationship to Subsc: ____________

Subscriber's Name: ______________Date of Birth: ________Soc Sec#:____________

Secondary Insurance Company: ______________________________Group#:____________

Policy/ID#: ______________ Patient Relationship to Subsc: ____________

Subscriber's Name: ______________Date of Birth: ________Soc Sec#:____________

Other Insurances? ____

Subscriber information:(if different from Patient or Parent/Guardian): __Primary __Secondary

Address : ____

City: ______________ State: ________ ZIP: ____________

Employer: ______________________________ W. Phone: ( )____________

Work Address: ______________ City: ____________ State: _____ Zip: ________

In case of Emergency, Contact: ______________________ Relationship: __________

Home Phone: ( ) __________ Work Phone: ( ) __________ Other: ( ) __________

Please read, sign, and date the following to allow us to bill your insurance company for your medical care:

I have completed this form and certify that I am the Patient or duly authorized agent of the patient authorized to furnish the information requested. I understand that even though I may have some type of insurance coverage, I am responsible for payment for services. I authorize the release of medical history, information, or records concerning my diagnosis and treatment by Capital Health Surgical Group required to substantiate or explain insurance claims filed, and I authorize payment directly to Capital Health Surgical Group and permit a copy of this authorization to be used in place of the original. This authorization will remain in effect until revoked by me in writing.

If I have Medicare coverage, I request that payment of authorized Medicare benefits be made either to me or on my behalf to Capital Health Surgical Group for any services furnished to me by that physician or supplier. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service.

____ ______________

Signature of Patient or Authorized Person (Address/Relationship) DATE

If I have Medigap coverage, I request that payment of authorized Medigap benefits be made either to me or on my behalf to Advanced Surgical Associates of New Jersey for any services furnished to me by that physician or supplier. I authorize any holder of Medicare information about me to release to

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(Name of Medigap Insurer)

any information needed to determine these benefits payable for related services.

____ ______________

Signature of Patient or Authorized Person (Address/Relationship) DATE

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I have read and reviewed the attached, and there are no changes to the information provided.

(To be re-signed once a year)

Signature: ______________________________ Date: ______________

Signature: ______________________________ Date: ______________

Signature: ______________________________ Date: ______________

Signature: ______________________________ Date: ______________

REV: 10/15/08