Eastern Surgical Associates
Specializing in Minimally Invasive Laparoscopic & Robotic Surgery

PATIENT INFORMATION

Patient Name Last_____ First_____ MI _____
Address_____
City _____ State_____ Zip_____ Phone_____
Sex_____ Race_____ Marital Status_____ Birthdate_____ Age_____
Retired_____ Employed_____ Full Time Student_____ Cell Phone_____
Employer_____ Phone_____
Social Security # _____ Drivers License_____
Person responsible for account_____ Relationship _____
Address_____
City_____ State_____ Zip_____ Phone_____
Employer _____ Phone_____
Social Security # _____ Drivers License_____
Spouse's Name_____ Employer_____ Phone_____
Person to notify in case of emergency_____ Phone _____
Drug allergies _____

INSURANCE POLICY INFORMATION

Insurance Company (Primary): _____
Policy holder's name_____ Birthdate_____
Employer_____
Contract number _____ Group _____
Relationship of patient to policy holder _____
Insurance Company (Secondary) _____
Policy holder's name _____ Birthdate_____
Employer_____
Contract number _____ Group _____
Relationship of patient to policy holder_____
Referred by _____

CONSENT FOR TREATMENT - I consent to necessary treatment, including drugs, medicine, performance of operations and conduct of X-ray, or other studies that may be used by the attending physician, his nurse or staff.

AUTHORIZATION FOR RELEASE OF INFORMATION - I authorize Eastern Surgical Associates, P.C. to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care, or my employer who is providing payment of my medical bills due to an on the job injury.

ASSIGNMENT OF BENEFITS - I hereby authorize payment directly to Eastern Surgical Associates, P.C. of benefits otherwise payable to me including major medical insurance and payment of surgical or medical benefits, but not to exceed Eastern Surgical Associates, P.C. charges for these services. I understand that I am financially responsible to Eastern Surgical Associates, P.C. for charges not covered by this assignment. I authorize the refund of overpaid insurance benefits where my coverages are subject to coordination of benefits.

GUARANTEE OF ACCOUNT - For services furnished by Eastern Surgical Associates, P.C. I hereby guarantee the payment of all accounts for services rendered. For payment of said accounts for services I hereby waive all claims of exemption under the State of Alabama and agree to pay, if necessary, all costs of collection, including attorney's fee.

SIGNATURE_____ **DATE**_____

Medication List

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies: _____

Pharmacy Name: _____ **Pharmacy Phone #:**_____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize the physicians and/or staff of Eastern Surgical Associate, P.C.to release information to:

Check all those that apply:

____ only to myself

____ any member of my family

____ only to the following people:

_____

_____

EASTERN SURGICAL ASSOCIATES, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have received the attached Notice of Privacy Practices.

_____	_____	_____
Patient or Personal Representative Printed Name	Patient or Personal Representative Signature	Date

If personal Representative's signature appears above, please describe Personal Representative's relationship to patient: _____

Medical History:

Surgical History:

Social History:

Do You Smoke: ____ Yes ____ No

Do You Drink: ____ Yes ____ No