Insurance and Individual Information

Do you have an "**Advanced Directive"** or **"Living Will"**?
Please ask the receptionist if you are unsure.
Yes No
If you circled yes, please bring a copy for our records.

Patient name: Last	First	Middle
Street address:	City, State and Zip code:	
Social Security Number	Date of birth	
Home phone number ( ) Work phone number ( )	Cell phone number ( ) E-mail address	
Patient's employer:	Employer's address:	

Primary Insurance Coverage	Secondary Insurance Coverage
Insured's name:	Insured's name:
Name of Insurance Co.:	Name of Insurance Co.:
Patient's relationship to insured:	Patient's relationship to insured:
ID#	ID#
Group#	Group#
Claims mailing address:	Claims mailing address:
Effective date:	Effective date:
Phone number (with area code):	Phone number (with area code):

Policy Holder/Spouse Information

Name :	Date of birth :	Work number:
Spouse's employer	Employer address:	
Contact person (other than spouse):	Relationship:	Phone number:

Billing Policy:

The Surgical Clinic, PLLC, will file your insurance. You, the patient, will be responsible for any balance remaining after insurance payment and any collection/attorney fees incurred in collecting that balance.

X _____ _____
Patient Signature Date