

DESERT WEST SURGERY PATIENT INFORMATION FORM

PATIENT INFORMATION

Who referred you to our office? _____

Who is your Primary Care Doctor or Family Doctor? _____

Birth date: ____/____/____ Marital Status _____

Your Name(Last)_____(First)_____(MI)_____

Address _____ Apt _____ City _____ St _____ Zip _____

Home Phone Number _____ Work Phone Number _____

Employer _____ Occupation _____

Employers Address _____ City _____ St _____ Zip _____

Social Security Number _____ - _____ - _____

Spouse or Guardian Information

Emergency Contact _____ **(Phone)** _____

Name of Spouse/Parent (Last)_____(First)_____(MI)_____

Employers Name _____ (Occupation) _____

Social Security Number _____ - _____ - _____ Birth date ____/____/____

Insurance Coverage Information

Primary Insurance Name _____

Address to send claims _____

Policy Number _____ Group Number _____

Policy Holders Name _____ Relationship to Patient _____

Secondary Insurance Name _____

Address to send claims _____

Policy Number _____ Group Number _____

Policy Holders Name _____ Relationship to Patient _____

If you do not have medical insurance please inform the front desk at this time, so that you can make arrangements with the billing department to pay your bill.

Insurance Authorization

I authorize treatment and I understand that I am financially responsible for all charges for services rendered to my spouse, child or myself. I understand that Desert West Surgery is billing my insurance as a courtesy and that I am ultimately responsible for seeing that my insurance carrier reimburses DWS. I authorize payment of medical benefits to the physicians of Desert West Surgery.

It is agreed that payments will not be delayed or withheld because of any insurance coverage and all proceeds are assigned to this office where applicable. (A copy of this is as valid as the original).

Signed: _____ Date: _____

Release of Information

The undersigned hereby authorizes and requests the physicians and staff of Desert West Surgery to provide any medical information necessary to process my medical claims with no limitation placed on dates, history or illness, diagnostic and therapeutic information, including any treatment for alcohol and/or drug abuse. I also give authorization for the physicians of Desert West Surgery to obtain or provide any information from my previous/current physicians or hospitals involved in my care with no limitations placed on dates, history or illness, diagnostic and therapeutic information, including any treatment for alcohol and/or drug abuse.

Patient

Date

If the patient is a minor or unable to sign, please complete the following:

Signature of Legal Representative/Other

Relationship to Patient

Reason Patient Unable to Sign

Witness Signature

***Please note that there is a charge of .60/page for the copying of medical records permissible by NRS 629.061.

****PLEASE GIVE ANY REPORTS, MEDICAL RECORDS OR X-RAYS TO THE FRONT DESK AT THIS TIME SO THAT THEY MAY BE INCLUDED IN YOUR CHART. THANK YOU****