TEXAS SURGERY ASSOCIATES

PATIENT INFORMATION

PATIENT NAME:	SEX: MALE FEMALE	
ADDRESS:		
CITY:	STATE:	ZIP:
TELEPHONE:	BIRTH DATE:	AGE:
CELL:	SOC. SEC #:	
OTHER:	DRIVER LICENSE #:	
EMPLOYER:	TELEPHONE: EXT.	
EMPLOYER ADDRESS:		
CITY:	STATE:	ZIP:
OCCUPATION/DEPARTMENT:		

HOW WERE YOU REFERRED TO THIS OFFICE? FRIEND:_____
DOCTOR:_____ HOSPITAL:_____
RELATIVE:_____ OTHER:_____

SPOUSE INFORMATION

NAME:	CELL:	
EMPLOYER:	TELEPHONE: EXT.	
EMPLOYER ADDRESS:		
CITY:	STATE:	ZIP:
BIRTH DATE:	SOC. SEC #:	

INSURANCE INFORMAITON

PRIMARY INSURANCE NAME:_____

INSURED NAME:_____ RELATIONSHIP TO PATIENT:_____

SECONDARY INSURANCE NAME:_____

INSURED NAME:_____ RELATIONSHIP TO PATIENT:_____

Please allow the receptionist to make copies of your Insurance cards.

RESPONSIBLE PARTY INFORMATION

NAME:	TELEPHONE:	
RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD OTHER:_____		
ADDRESS:		
CITY:	STATE:	ZIP:
SOC. SEC. NO:	DRIVER LICENSE #:	

EMERGENCY CONTACT (PLEASE LIST SOMEONE WHO DOES NOT LIVE WITH YOU)

NAME:	TELEPHONE:	
ADDRESS:		
CITY:	STATE:	ZIP:
RELATIONSHIP TO PATIENT: SPOUSE PARENT CHILD FRIEND OTHER:_____		
Is condition **JOB** or **AUTOMOBILE** related? YES NO If **YES** please notify the receptionist for verification of your insurance!		

Payment is expected when services are rendered unless previous arrangements have been made with the management!

ASSIGNMENT OF BENEFITS

I authorize the release of any medical or other information necessary to the Health Care Financing Administration or its intermediaries. I permit a copy of this authorization to be used in place of an original, and request payment of medical benefits to be paid directly to **TEXAS SURERY ASSOCIATES.**

SIGNATURE:	**DATE:**