

# SUFFOLK SURGICAL GROUP, P.C.

## PATIENT INFORMATION

REFERRED BY:

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DATE OF BIRTH \_\_\_\_ / \_\_\_\_ / \_\_\_\_ AGE \_\_\_\_\_

MARITAL STATUS: Single Married Widowed Divorced Separated / SEX:  MALE  FEMALE

ADDRESS \_\_\_\_\_ APT # \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME PHONE: ( ) \_\_\_\_\_ CELL PHONE: ( ) \_\_\_\_\_

EMPLOYER NAME \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_ HOW LONG EMPLOYED \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

BUSINESS PHONE: ( ) \_\_\_\_\_ **EMAIL ADDRESS** \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

HOME PHONE: ( ) \_\_\_\_\_ WORK/CELL: ( ) \_\_\_\_\_

## HEALTH INSURANCE INFORMATION

PLEASE SUBMIT ALL INSURANCE CARDS  
AND DRIVER'S LICENSE / PHOTO ID FOR  
SCANNING

### PRIMARY INSURANCE

COMPANY \_\_\_\_\_

MEMBER ID \_\_\_\_\_ GROUP NO. \_\_\_\_\_

ADDRESS \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_

PHONE: ( ) \_\_\_\_\_ GROUP NAME \_\_\_\_\_

**POLICY HOLDER INFORMATION: NAME** \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_ SEX: ( ) M ( ) F

PATIENT'S RELATION TO INSURED \_\_\_\_\_

EMPLOYER NAME AND ADDRESS \_\_\_\_\_

EMPLOYER PHONE \_\_\_\_\_

### SECONDARY INSURANCE COMPANY

MEMBER ID \_\_\_\_\_ GROUP NO. \_\_\_\_\_

ADDRESS \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_

PHONE: ( ) \_\_\_\_\_ GROUP NAME \_\_\_\_\_

**POLICY HOLDER INFORMATION: NAME** \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_ SEX: ( ) M ( ) F

PATIENT'S RELATION TO INSURED \_\_\_\_\_

EMPLOYER NAME AND ADDRESS \_\_\_\_\_

EMPLOYER PHONE \_\_\_\_\_

## INSURANCE AUTHORIZATION AND ASSIGNMENT

IF YOU HAVE NO INSURANCE, YOU WILL BE REQUIRED TO PAY AT TIME OF SERVICE.  
IF YOUR INSURANCE REQUIRES A REFERRAL AND YOU DO NOT HAVE ONE, YOUR APPOINTMENT  
WILL HAVE TO BE RESCHEDULED.

I HEREBY AUTHORIZE \_\_\_\_\_ M.D. TO FURNISH INFORMATION TO INSURANCE CARRIERS  
CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR

MEDICAL SERVICES RENDERED TO ME OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_