

# PARAGON SURGICAL SPECIALISTS

## PATIENT INFORMATION

Name \_\_\_\_\_  
(Last) (First) (Middle) (Maiden)

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

Social Security \_\_\_\_\_ Marital Status (Circle One) S - M - W - D

Birthdate \_\_\_\_\_ M - F (Circle One)

Cell Number \_\_\_\_\_ Email Address \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_

### EMERGENCY CONTACT

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Work Phone \_\_\_\_\_

Cell or Home Phone \_\_\_\_\_

### PRIMARY POLICYHOLDER INFORMATION

Policyholder's Employer \_\_\_\_\_

Policyholder's Name \_\_\_\_\_

Policyholder's Date of Birth \_\_\_\_\_

Policyholder's SS# \_\_\_\_\_

### SECONDARY POLICYHOLDER INFORMATION

Policyholder's Employer \_\_\_\_\_

Policyholder's Name \_\_\_\_\_

Policyholder's Date of Birth \_\_\_\_\_

Policyholder's SS# \_\_\_\_\_

**DEDUCTIBLE AND CO-PAYS ARE DUE AND PAYABLE AT TIME OF SERVICE! THIS ALSO INCLUDES SURGERY CHARGES. IF WE ARE NOT CONTRACTED WITH YOUR INSURANCE COMPANY, FULL PAYMENT IS DUE AT THE TIME OF SERVICE.** As a courtesy, we will file your insurance claim for your reimbursement.

I will pay my visit by Cash \_\_\_\_\_ Check \_\_\_\_\_ Credit Card \_\_\_\_\_

**MEDICARE PATIENTS:** Your deductible and co-pays are due at the time of service unless you can show your deductible has been met and you have supplemental coverage for your co-payments.

**MEDICAID PATIENTS:** You must present a copy of your current card in order to be seen. Co-pays must be paid at the time of service. Hospital co-pays are due on your first visit after hospitalization.

**WORKERS' COMPENSATION:** You must present a claim number & employers phone number. We will call your employer to validate your claim. If it is not authorized, you must pay for today's visit.

➡ Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Patient)

**IF PATIENT IS A MINOR:** I, \_\_\_\_\_, custodial

Parent/Legal guardian of \_\_\_\_\_

do hereby give my permission to PARAGON SURGICAL SPECIALISTS to treat him/her. I accept financial responsibility for such treatments.

Signed \_\_\_\_\_ Signed \_\_\_\_\_  
Witness Custodial Parent/Legal Guardian

**AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE COMPANY: (In order to file your insurance, you must sign and date this authorization.)**

I hereby authorize **Paragon Surgical Specialists** to release any medical and other information necessary to process my insurance claims. I further authorize payment of medical benefits to Paragon Surgical Specialists for my services. I understand this authorization allows the release of all information in my file, including information regarding any chemical dependency problems and/or treatment and HIV testing. I further understand that I may revoke this authorization in writing at any time.

➡ Date \_\_\_\_\_ Patient/Guardian \_\_\_\_\_