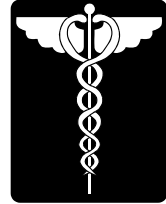


Patient Information

North Dallas Surgical Specialists, P.A.



Please Print

Legal Name – Last: _____ First: _____ M.I. _____ Nickname _____

Address: _____ City: _____ State: _____

Zip Code: _____ Home Phone: (____) _____ Cell Ph/Pager: (____) _____

Age: _____ Birthdate: ____/____/____ Sex: M F Social Security #: _____-_____-_____

Drivers License #: _____ Marital Status: Single Married Divorced Widow(er)

Relationship to responsible party: Self Spouse Child Other

Referring Doctor: _____ Phone: (____) _____

Primary Care Physician: _____ Phone: (____) _____

Employer: _____ Employer address: _____

City: _____ State: _____ Zip Code: _____ Business Phone: (____) _____

Contact Information

Please list all phone numbers—in order of preference—where we may contact you:

Please list those we have your permission to speak with regarding your health information:

Location/Type

(Home, Work, Cell, etc.)	Phone Number
1. _____	(____) _____
2. _____	(____) _____
3. _____	(____) _____

Name	Relationship	Phone Number
1. _____	_____	(____) _____
2. _____	_____	(____) _____
3. _____	_____	(____) _____

Check here if it is OK to leave a message on your answering machine (or voice mail)

Insurance Information

Is your condition related to an on-the-job injury? (i.e., is this a worker's compensation claim?) Yes No

Primary Carrier

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Insurance Co: _____

Secondary Carrier

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Insurance Co: _____

Responsible Party Statement and Payment of Benefits

As the responsible party, I understand that my health insurance policy is an arrangement between my insurance carrier and myself. This office will prepare any necessary reports and forms to assist me in making collection from the insurance company, however, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for all charges for services rendered. All charges not paid by my insurance company will be my responsibility. Fees for services are due at the time the services are rendered. I am aware that the doctor may refer me to a surgery center in which he has a partial ownership stake. I authorize payment of benefits as determined by the insurance company directly to the physician.

Signature: X _____ Today's Date: ____/____/____