

**GENERAL INFORMATION**

PATIENT LAST NAME		FIRST NAME (legal)		MI	PREFERRED OR NICKNAME	
DATE OF BIRTH	SEX M F	RACE ETHNICITY		SOCIAL SECURITY # PREFERRED LANGUAGE		
MAILING ADDRESS			APT#	CITY	STATE	ZIP CODE 4 DIGIT
STREET ADDRESS			APT#	CITY	STATE	ZIP CODE 4 DIGIT
HOME PHONE		WORK PHONE	EXT	CELL PHONE		
REFERRING DOCTOR				MARITAL STATUS		
PRIMARY CARE DOCTOR				MARRIED _____ DIVORCED _____ SINGLE _____ WIDOWED _____ SEPARATED _____		
PREFERRED EMAIL ADDRESS						

PATIENT EMPLOYER (IF NOT EMPLOYED ARE YOUR RETIRED _____ OR DISABLED _____)

EMPLOYER NAME			OCCUPATION			
STREET ADDRESS			CITY	STATE	ZIP CODE 4 DIGIT	

PRIMARY INSURANCE

INSURANCE COMPANY NAME		RELATION TO SUBSCRIBER		COPAY	
SUBSCRIBER'S NAME		SUBSCRIBER'S EMPLOYER			
SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SEX MALE _____ FEMALE _____	SUBSCRIBER'S ID #		GROUP NUMBER	

SECONDARY INSURANCE

INSURANCE COMPANY NAME		RELATION TO SUBSCRIBER		COPAY	
SUBSCRIBER'S NAME		SUBSCRIBER'S EMPLOYER			
SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SEX MALE _____ FEMALE _____	SUBSCRIBER'S ID #		GROUP NUMBER	

RESPONSIBLE PARTY WHO IS RESPONSIBLE FOR THE REMAINING BALANCE ON THIS ACCOUNT?

_____ SELF (*IF SELF DO NOT FILL IN RIGHT FIELD) _____ SPOUSE _____ PARENT _____ GUARDIAN	SOCIAL SECURITY #		LAST NAME		FIRST NAME		MI
	STREET ADDRESS			CITY	STATE	ZIP CODE 4 DIGIT	
	HOME PHONE		WORK OR CELL PHONE		EXT	DATE OF BIRTH	SEX M F
WORKER'S COMP CLAIM #	DATE OF INJURY	EMPLOYER			STATE OR SELF INSURED?		

RELEASE OF BENEFIT AND INFORMATION

I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO PROLIANCE SURGEONS, INC. I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE DUE, INCLUDING MONTHLY SERVICE CHARGES ON PATIENT BALANCES OVER 60 DAYS.

I AUTHORIZE THE DOCTOR OR INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED FOR THIS CLAIM.

PATIENT SIGNATURE _____ DATE _____