BayChoice Surgeons

Patient Information

Name (First to Last)	Social Security Number	Marital Status	Age	Gender	Birth Date
	– –	S | M | D | W		Male / Female	/ /

Address- Street name and number	Home Phone Number	Work Phone Number
	( ) -	( ) -
City/ State/ Zip Code	**Cell/Pager Phone Number**	**Driver's License Number**
	( ) -	

Employer Name/ Place of Employment	Employer's Address/ City/ State/ Zip Code	Occupation

Emergency Contact- PLEASE GIVE: NAME, RELATIONSHIP, AND PHONE NUMBER OF PERSON ***NOT*** LIVING WITH YOU.	E-Mail Address

Injured Area or Presenting Problem	Date of Injury or Indication of Problem	How did you hear about us or who were you referred by?

Guarantor Information

THIS SECTION IS REQUIRED. PLEASE FILL OUT ALL INFORMATION ASKED. COMPLETE THIS SECTION WITH THE INSURED/ POLICYHOLDER'S INFORMATION, AND IF THE PATIENT IS UNDER 18 YEARS OLD.

Name	Social Security Number	Relationship of Patient to Responsible Party	Gender	Birth Date
	– –	Spouse | Child | Other	Male / Female	/ /

Address- Street number & name/ City/ State/ Zip Code	Home Phone Number
	( ) -

Employer Name/ Place of Employment Employer's Address/ City/ State/ Zip Code	Work Phone Number	Occupation
	( ) -	

Insurance Information

PLEASE PRESENT YOUR INSURANCE CARD & PICTURE ID TO OUR RECEPTIONIST.

☐ Medicare	☐ Medicaid		☐ Automobile Accident
ID Number:	ID Number:		Date: / /

☐ Insurance	ID Number:	Group Number	Policyholder or Insured:
Company Name:			☐ Self ☐ Spouse ☐ Parental ☐ Other: ______
☐ Additional/ Secondary Insurance	ID Number:	Group Number	Policyholder or Insured:
Company Name:			☐ Self ☐ Spouse ☐ Parental ☐ Other: ______

****Please fill out the information below *ONLY* if the policyholder/ insured is *NOT* you or the guarantor for your *secondary insurance*.**

Name	Social Security Number	Relationship of Patient to Responsible Party	Gender	Birth Date
	– –	Spouse | Child | Other	Male / Female	/ /

Address- Street number & name/ City/ State/ Zip Code	Home Phone Number
	( ) -

Employer Name/ Place of Employment Employer's Address/ City/ State/ Zip Code	Work Phone Number	Occupation
	( ) -	

I request that payment of authorized insurance benefits be made on my behalf to the provider indicated above for any services furnished to me. I authorize that any holder of medical information about me or my dependant to be release to the insurance company. Any information needed to determine these benefits payable for related services for 90 days form the date below. A copy of this assignment is to be considered as valid as the original. **I understand that I am financially responsible for all charges whether or not covered by said insurance.** I hereby authorize the attending physician to instruct his Nurse and/ or Physician Assistant to assist him with certain aspects of my medical condition. I understand that the Nurse and/ or Physician Assistant is not a licensed physician and may not diagnose any illness, injury or medical condition except under the supervision and direction of a licensed physician. I understand that I may revoke this authorization at any time.

Patient/ Guarantor's Signature ______________________ **Date:** ____________