

# LAPAROSCOPIC & ENDOSCOPIC SURGERY INSTITUTE, PC

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Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**IT IS YOUR RESPONSIBILITY TO PRESENT YOUR INSURANCE CARD  
AND NOTIFY US OF ANY CHANGES AT EACH APPOINTMENT**

**PATIENT INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone \_\_\_\_\_ Cell Telephone \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Marital Status (circle one) Single Married Other \_\_\_\_\_ Spouse Name \_\_\_\_\_

**EMPLOYER or SCHOOL INFORMATION**

Employer or School \_\_\_\_\_ Work Telephone \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Street Address- \_\_\_\_\_ Home Telephone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Work Telephone \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Insurance Company** \_\_\_\_\_ Name of Insured: \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_ Insured Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Mailing Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone Number: \_\_\_\_\_

**Secondary Insurance Company** \_\_\_\_\_ Name of Insured \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_ Insured Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone Number: \_\_\_\_\_

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**ASSIGNMENT OF BENEFITS/GUARANTEED OF PAYMENT:** I authorize payment of medical benefits to Laparoscopic & Endoscopic Surgery for services rendered. I understand that if I have provided valid insurance information that my charges will be filed for any benefits due. However, I am financially responsible for any charges incurred & not covered by my insurance company and do hereby agree to pay for these services in full.

\_\_\_\_\_  
Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

