

LAPAROSCOPIC & ENDOSCOPIC SURGERY INSTITUTE, PC

Today's Date: ___/___/___

5755 North Point Parkway Suite 223
Alpharetta, GA 30022
(770)500-3660 (Telephone)
(770)500-3664 (Fax)

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: _____

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 ___/___/___