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: _____

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ASSIGNMENT OF BENEFITS/GUARANTEE 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