MONTEREY COUNTY SURGICAL ASSOCIATES

PATIENT INFORMATION

PATIENT'S NAME: _____ SEX: M ☐ F ☐ BIRTHDATE: ____/____/____
LAST FIRST MIDDLE

ADDRESS: _____ HOME PHONE: (____)____
NUMBER AND STREET CITY STATE ZIP

PATIENT'S EMPLOYER: _____ WORK PHONE: (____)____
NAME AND ADDRESS

OCCUPATION: _____ SOCIAL SECURITY #: _____

MARITAL STATUS: S ☐ M ☐ W ☐ D ☐ PARENT'S OR SPOUSE'S NAME: _____

PARENT OR SPOUSE'S EMPLOYER: _____ PHONE: (____)____

REFERRING PHYSICIAN: _____ FAMILY PHYSICIAN: _____

FRIEND OR RELATIVE WE CAN CONTACT IN CASE OF EMERGENCY:

NAME: _____ RELATIONSHIP: _____ PHONE: (____)____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

SUBSCRIBER'S NAME: _____

SEX: M ☐ F ☐ BIRTHDATE: ____/____/____ SS#: _____

PATIENT'S RELATIONSHIP TO SUBSCRIBER: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE COMPANY: _____

SUBSCRIBER'S NAME: _____

SEX: M ☐ F ☐ BIRTHDATE: ____/____/____ SS#: _____

PATIENT'S RELATIONSHIP TO SUBSCRIBER: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

MEDICARE PATIENTS ONLY: Please read and sign

LIFETIME AUTHORIZATION FOR MEDICARE

I request that payment of authorized Medicare benefits be made on my behalf to BENNER, GARZA, HYDE, LURIE, STUNTZ, VERLENDEN, AND VIERRA, M.D'S (d.b.a. MONTEREY COUNTY SURGICAL ASSOCIATES) for any services furnished me by these physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If other health insurance coverage is indicated in Item 9 of the NCFA 1500 claim form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and deductible are based upon the charge determination of the Medicare carrier.

Patient's Signature: _____ Date: _____

ALL OTHER INSURANCE/MEDI-CAL PATIENTS: Please read and sign

LIFETIME AUTHORIZATION FOR ALL OTHER INSURANCE/MEDI-CAL

I hereby authorize the release of pertinent medical and other information to my insurance carriers to assist processing insurance claims.
I hereby authorize my insurance benefits to be paid directly to BENNER, GARZA, HYDE, LURIE, STUNTZ, VERLENDEN AND VIERRA, M.D'S (d.b.a. MONTEREY COUNTY SURGICAL ASSOCIATES).
I understand I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

Patient's Signature: _____ Date: _____

SELF-PAY PATIENTS: Please read and sign

I understand I AM RESPONSIBLE FOR ANY CHARGES INCURRED IN THIS OFFICE.

Patient's Signature: _____ Date: _____