Barrington Surgeons, Ltd.
PATIENT INFORMATION

Patient Name (First, Middle, Last): _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Sex: __**M** ____**F** **Birthdate:** _____ **Social Security Number:** _____

Home Phone: _____ **Cell Phone:** _____ **Work:** _____

E-mail: _____

Primary Care Physician: _____ **Phone No.** _____

Whom May We Thank for Referring You? _____

Spouse's Name: _____ **Date of Birth:** _____

Parent Name(s) (If Minor) _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

INSURANCE INFORMATION

Insurance Name: _____ **Group #** _____**ID#** _____

Insured's Name: _____ **Insured's SS #:** _____

Insured's Employer: _____ **Insured's DOB:** _____

Patient Relationship to Insured: _____**Self** _____**Spouse** _____ **Dependent (Check One)**

Secondary Insurance: _____ **Group #**_____**ID #**_____

Insured's Name:_____ **Insured's SS#:** _____

Insured's Employer: _____ **Insured's DOB:** _____

Patient Relationship to Insured: _____**Self**____**Spouse** _____ **Dependent (Check One)**

I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I also authorize release of medial information including the diagnosis and records of any treatment or examination by other Doctors or facilities. I am also aware that your office will file my insurance claims as a courtesy. However, I am aware that I am responsible for the bill.

Signed: _____ **Date:** _____

Signed: _____ **Date:** _____

Signed: _____ **Date:** _____