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? ____

Name of Pharmacy you currently use: ___________________________

Pharmacy Address:_________________________ **City:**_________**State:**_______ **Zip:**____________

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:** _____________________