Appt Date _____

West Michigan Surgical Specialists, PLC

Acct No: _____

PATIENT:

Legal Name (Last) _____ (First) _____

Male ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Child ☐

Female ☐ Parent or Spouses Name _____

Date of Birth _____ Social Security Number _____

Address _____ Apartment No _____

City _____ State _____ Zip _____

First Phone _____ Home ☐ Cell ☐ Second Phone _____ Home ☐ Cell ☐

Work Phone _____ Department _____ Extension _____

Email Address _____

Family Doctor _____ Referring Doctor _____

EMPLOYMENT: Full Time ☐ Part Time ☐ Retired ☐ Unemployed ☐

Employer Name: _____

Work Related Injury ? Yes ☐ No ☐ Date of Injury _____

Auto Related Injury? Yes ☐ No ☐ Date of Injury _____

EMERGENCY CONTACT:

Name _____ Relationship _____ Phone _____

PRIMARY INSURANCE: Name of Insurance _____

Employer _____

Person who carries this insurance _____ Relationship _____

Date of Birth _____ Social Security Number _____

SECONDARY INSURANCE: Name of Insurance _____

Employer _____

Person who carries this insurance _____ Relationship _____

Date of Birth _____ Social Security Number _____

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign all benefits including Medicare, Medicaid, BCBS, private insurance, and any other group health plans to West Michigan Surgical Specialists PLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize West Michigan Surgical Specialists PLC to release all information necessary to secure payment.

SIGNED _____ DATE _____