

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 Phone: _____

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: _____