

CHART # _____

PATIENT INFORMATION

SELF PAY

SURGICAL INSTITUTE OF SOUTH DAKOTA, P.C.

WORK COMP

911 EAST 20TH STREET, SUITE 800 • SIOUX FALLS, SD 57105-1050

MVA

DATE: _____

PATIENT: _____ SOC. SEC. #: _____

CHECK APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

BIRTHDATE: _____ AGE: _____ SEX: MALE FEMALE

HOME ADDRESS: _____ CITY _____ STATE _____ ZIP _____

MAILING ADDRESS: _____ CITY _____ STATE _____ ZIP _____

HOME PHONE: (_____) _____ WORK PHONE (_____) _____

CELL PHONE: (_____) _____

EMPLOYER: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____ CITY _____ STATE _____ ZIP _____

SPOUSE'S FULL NAME: _____

SPOUSE'S EMPLOYER: _____

SPOUSE'S WORK #: (_____) _____ SPOUSE'S SOC SEC #: _____

SPOUSE'S CELL #: (_____) _____ SPOUSE'S D.O.B.: _____

FRIEND OR RELATIVE
(NOT LIVING AT ABOVE ADDRESS) _____ PHONE: (_____) _____

ADDRESS: _____ CITY _____ STATE _____ ZIP _____

RELATIONSHIP: _____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

NAME: _____

SOC SEC #: _____ D.O.B.: _____ RELATIONSHIP _____

ADDRESS: _____ CITY _____ STATE _____ ZIP _____

PHONE: (_____) _____ OCCUPATION: _____

EMPLOYER: _____

REFERRAL INFORMATION

HOW DID YOU HEAR ABOUT OUR OFFICE: _____

NAME OF REFERRING PHYSICIAN: _____ PHONE: (_____) _____

ADDRESS: _____ CITY _____ STATE _____ ZIP _____

INSURANCE INFORMATION

PRIMARY INSURANCE COVERAGE INFORMATION:

POLICY HOLDER NAME _____

SEX: MALE FEMALE

POLICY HOLDER DATE OF BIRTH _____

SOC. SEC. NO. _____

NAME OF INSURANCE CO _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (____) _____

GROUP # _____

PLAN/ID NO. _____

SECONDARY INSURANCE COVERAGE INFORMATION:

POLICY HOLDER NAME _____

SEX: MALE FEMALE

POLICY HOLDER DATE OF BIRTH _____

SOC. SEC. NO. _____

NAME OF INSURANCE CO _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (____) _____

GROUP # _____

PLAN/ID NO. _____

DOES YOUR INSURANCE REQUIRE A SECOND OPINION PRIOR TO SURGERY? YES NO

DOES YOUR INSURANCE REQUIRE PRE-AUTHORIZATION PRIOR TO SURGERY? YES NO

MEDICARE#: _____ MEDICAID#: _____

MOTOR VEHICLE ACCIDENT

IF YOU HAVE BEEN INVOLVED IN A CAR ACCIDENT, PLEASE INFORM US OF YOUR AUTO INSURANCE:

NAME OF COMPANY: _____ ID/POLICY #: _____

ADDRESS: _____ INSURED: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE SURGICAL INSTITUTE TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS.

I HEREBY ASSIGN TO THE PHYSICIAN(S), ALL PAYMENTS FOR MEDICAL AND/OR SURGICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED INCLUDING PRIVATE AND OTHER HEALTH COVERAGE.

THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THE ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE.

SIGNATURE: _____ DATE: _____

MEDICARE AUTHORIZATION

I REQUEST THAT PAYMENTS OF AUTHORIZED MEDICARE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO SURGICAL INSTITUTE FOR ANY SERVICES FURNISHED ME BY SURGICAL INSTITUTE. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO BE RELEASED TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THOSE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

SIGNATURE: _____ DATE: _____

TESTING FOR HIV (AIDS) AND/OR HEPATITIS

THE UNDERSIGNED CONSENTS TO TESTING FOR HIV (AIDS) AND/OR HEPATITIS SHOULD A HEALTHCARE WORKER HAVE ACCIDENTAL EXPOSURE TO MY BLOOD OR OTHER BODY SUBSTANCE, OR IN THE EVENT TESTING IS DIRECTED BY MY PHYSICIAN.

I CERTIFY THAT I HAVE READ AND HEREBY AUTHORIZE THE ABOVE.

SIGNATURE: _____ DATE: _____