

CHART # \_\_\_\_\_

PATIENT INFORMATION

SELF PAY

**SURGICAL INSTITUTE OF SOUTH DAKOTA, P.C.**

WORK COMP

911 EAST 20<sup>TH</sup> 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: \_\_\_\_\_