Surgical Institute of South Dakota, P.C.

911 East 20th Street, Suite 700 ● Sioux Falls, SD 57105

Date:___________________________

PATIENT INFORMATION

Patient Full Legal Name:______________________________Nickname:______________

DOB:__________________ Age:__________ SSN:__________________ Sex: ☐ Male ☐ Female

Home Address:____________________City:________________ State:______Zip:______

Mailing Address:____________________City:________________ State:______Zip:______

Home/Cell Phone:______________________Other/Cell Phone:______________________

Email Address:____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic partner/Significant other

Race: ☐ Asian ☐ Black/African American ☐ White/Caucasian ☐ Hispanic ☐ Native American ☐ Pacific Island/Native Hawaiian ☐ Other

Employer:__________________ Occupation:__________________ Phone:______________

Employer Address:____________________City:________________ State:______Zip:______

NEXT OF KIN

Next of Kin Name:________________________ Relationship to Patient:______________

Address:____________________City:________________ State:______Zip:______

Home/Cell Phone:______________________Other/Cell Phone:______________________

PERSON TO NOTIFY

Person to Notify Name:________________________ Relationship to Patient:______________

Address:____________________City:________________ State:______Zip:______

Home/Cell Phone:______________________Other/Cell Phone:______________________

RESPONSIBLE PARTY

Guarantor Name:________________________ Relationship to Patient:______________

Address:____________________City:________________ State:______Zip:______

Home/Cell Phone:______________________Other/Cell Phone:______________________

Email Address:____

DOB:__________________ Age:__________ SSN:__________________ Sex: ☐ Male ☐ Female

Employer:__________________ Occupation:__________________ Phone:______________

Employer Address:____________________City:________________ State:______Zip:______

REFERRAL INFORMATION

Referring Physician:______________________________ Phone:______________

Address:____________________City:________________ State:______Zip:______

Primary Care Physician:______________________________ Phone:______________

Address:____________________City:________________ State:______Zip:______

AUTO INSURANCE /WORKERS COMPENSATION

Is this visit covered by liability insurance such as auto insurance or workers compensation? ☐ YES ☐ NO

If yes, I agree to provide Surgical Institute all information necessary to bill said liability insurance on my behalf.

Signature:______________________________ **Date:**______________

PATIENTS WITHOUT INSURANCE/SELF PAY PATIENTS

I understand that I am responsible for all of my charges because I do not have health insurance. If I do obtain health insurance in the future, I agree to provide Surgical Institute with my insurance information.

Signature:______________________________ **Date:**______________

PATIENTS WITH HEALTH INSURANCE

Please bring your insurance card(s) to your appointment so that we can scan them into our computer billing system.

Primary Insurance:

Insurance Company Name:______________________

Address:______________________

City:______________ State:____ Zip:______

Insurance Phone:______________________

Subscriber Name:______________________

Address:______________________

City, State, Zip:______________________

Phone:______________________

DOB:__________ SSN:______________

Group #:______________________

Patient Policy #:______________________

Subscriber Policy #:______________________

Effective Date:______________________

Secondary Insurance:

Insurance Company Name:______________________

Address:______________________

City:______________ State:____ Zip:______

Insurance Phone:______________________

Subscriber Name:______________________

Address:______________________

City, State, Zip:______________________

Phone:______________________

DOB:__________ SSN:______________

Group #:______________________

Patient Policy #:______________________

Subscriber Policy #:______________________

Effective Date:______________________

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:**______________