Salisbury Uro Surgical Center LLC

Patient Name: ______________________________ **Social Security #:** ______________________

Address: ____
Street **City** **State** **Zip**

Date of Birth: ____________________ **Marital Status: S M D W Sep.** **Race: W B O**

Cell Phone: __________________________ **Home Phone:** ______________________________

Employer: ____ **Phone:** ______________

Employer Address: ____

Spouse/Nearest Relative: ______________ **Relationship:** ____________ **Phone:** ______________

Emergency Relative other than spouse: _________________________ **Phone:** ______________

Primary Insurance Co: ______________________________ **Employer:** ______________________

Name of Subscriber as it appears on card: ____

Address of Insurance Co. ____
Street **City** **State** **Zip**

Policy #: ______________________ **Group** ______________ **ID#** ____________________

Secondary Ins. Co: ______________________________ **Employer:** ______________________

Name of Subscriber as it appears on card: ____

Address of Insurance Co: ____
Street **City** **State** **Zip**

Policy#: ______________________ **Group** ______________ **ID#** ____________________

WE REQUEST PAYMENT AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE

AUTHORIZATION: I acknowledge responsibility for payment of fees and authorize release of information necessary to process my medical claims. I assign and request payment of medical benefits to named physician for services noted on FEE SLIP as agreed:

SIGNATURE: ____________________________________ **DATE:** ______________________

PLEASE REMEMBER TO BRING ANY INSURANCE CARDS WITH YOU AT THE TIME OF YOUR OFFICE VISIT.

Thank You