

# Oklahoma Surgicare

## PATIENT INFORMATION

PATIENT NAME: \_\_\_\_\_  
SURGEON: \_\_\_\_\_  
ANESTHESIOLOGIST : \_\_\_\_\_  
DATE OF SURGERY: \_\_\_\_\_

### PATIENT INFORMATION

NAME \_\_\_\_\_  
(first) (middle) (last) DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_  
MARITAL STATUS \_\_\_\_\_ SEX \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
Zip \_\_\_\_\_ SS# \_\_\_\_\_  
HOME PHONE \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
ADDRESS \_\_\_\_\_ NEAREST RELATIVE \_\_\_\_\_  
Zip \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_  
PERSON DRIVING YOU HOME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

RACE:  AMERICAN INDIAN OR ALASKAN NATIVE  BLACK/ AFRICAN AMERICAN  OTHER  
 ASIAN OR PACIFIC ISLANDER  WHITE

ETHNICITY:  HISPANIC ORIGIN  NOT OF HISPANIC ORIGIN

### RESPONSIBLE PARTY

NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
ADDRESS \_\_\_\_\_ ADDRESS \_\_\_\_\_  
Zip \_\_\_\_\_ ZIP \_\_\_\_\_  
PHONE# \_\_\_\_\_ PHONE # \_\_\_\_\_

### INSURANCE INFORMATION

Primary

Secondary

INS. COMPANY _____	INS. COMPANY _____
POLICY HOLDER _____	POLICY HOLDER _____
SS# _____	SS# _____
MAIL TO: _____	MAIL TO: _____
POLICY # _____	POLICY # _____
GROUP # _____	GROUP # _____
PHONE # _____	PHONE # _____
Have you verified coverage? _____	Have you verified coverage _____
%INSURANCE WILL PAY AN ASC _____	%INSURANCE WILL PAY AN ASC _____

### AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby assign payment directly to Oklahoma Surgicare all Surgical and / or Medical Benefits, otherwise payable to me for its services but not to exceed its charges. Any unpaid deductible and / or estimated co-pay are due and payable the day of surgery. I understand that charges not payable by insurance are my responsibility and all charges are due in full within 90 days from the date-of-surgery regardless of any insurance pending.

I also authorize Oklahoma Surgicare to release any information (to include information regarding communicable or venereal diseases) acquired in the course of examination or treatment to my insurance company, peer review or hospital if transferred for follow-up care.

\*\*Photostat of the above is considered as valid as the original.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_