ANDREW L. SIMON, M.D., F.A.C.S

Patient Information Form

Social Security #_____ Birth Date_____ Age_____

Last Name_____ First Name_____ M.I._____

Address_____

City_____ State_____ Zip_____ Email Address _____

Home Phone_____ Cell_____ Work_____

Marital Status: Single Married Divorced Widowed Other_____

Ethnic Group: Unknown Hispanic Non- Hispanic Other_____

Race: Asian White/Caucasian Black/African American American Indian Other_____

Language: English Spanish Sign Language Other_____

Employer Information Employer's Name_____ Patient's Occupation_____

Insurance Information- Primary/Secondary/Other. Present each card at every visit

Primary Insurance Company

Name_____ Address _____

Policy #_____Group # _____

Subscriber Name_____ Subscriber DOB _____

Social Security #_____Subscriber Relationship to Patient _____

Subscriber Address _____

Secondary Insurance Company

Name_____Address_____

Policy #_____Group #_____

Subscriber Name_____ Subscriber DOB_____

Social Security#_____ Subscriber's Relationship to Patient_____

Subscriber Address_____

Pharmacy Name: _____ Address_____Phone_____

Emergency Contact

In case of an emergency, we may contact_____ Relationship_____

Phone_____

Primary Care Physician: _____ Phone:_____

Referred by:_____

Payment is expected at the Time of Service

Authorization for Payment

I, Undersign herby authorize payment of medical benefits to Andrew L. Simon, M.D., F.A.C.S., P. A. for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my contract. I authorize release of information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

Authorization for Medicare

I request that payment of authorized Medicare benefits be made on my behalf to Andrew L. Simon, M.D., F.A.C.S., P.A. for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent information needed to determine these benefits payable for related services.

_____ _____

Signature of Patient (or Guardian) Date Signature of Patient Date