Name:
Chart:
Date:

Wilmington Surgical Associates, PA **Patient Information Sheet**

Patient Full Name: First: _____ Middle: _____ Last: _____ Suffix: _____

Date of Birth: _____ Social Security Number: _____

Patient Cell Number: _____ Patient Home Number: _____

Name of Spouse/Guardian/Power of Attorney: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____ Number: _____

Name: _____ Relationship: _____ Number: _____

Primary Medical Doctor: _____ who referred you? _____

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION TO THE FOLLOWING PARTIES

I hereby authorize you to release any personal health information to the following parties and understand that this communication may occur either verbally or by releasing copies of my medical record. This authorization will remain in effect until such time that I revoke it.

Name: _____ Date: _____ Patient Signature: _____

Name: _____ Date: _____ Patient Signature: _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I hereby acknowledge receipt.

Date: _____ Patient Signature: _____

If not signed, reason why acknowledgement was not obtained: _____

Date: _____ Employee Signature: _____

ACKNOWLEDGEMENT OF RECEIPT OF FINANCIAL POLICY

I hereby acknowledge receipt.

Date: _____ Patient Signature: _____

If not signed, reason why acknowledgement was not obtained: _____

Date: _____ Employee Signature: _____

ASSIGNMENT OF BENEFITS

I hereby assign to Wilmington Surgical Associates, PA any insurance or other third-party benefits available for health care services provided to me. I understand that Wilmington Surgical Associates, PA has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Wilmington Surgical Associates, PA, I agree to forward to Wilmington Surgical Associates, PA all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

I acknowledge receipt of the financial policy of Wilmington Surgical Associates, PA. I guarantee payment of any balance not covered by my insurance company and/or I guarantee payment if I do not have insurance coverage.

Date: _____ Patient Signature: _____

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