

**PLEASE PRINT and/or CIRCLE THE REQUESTED INFORMATION**

**Patient Information:** Social Security Number: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
Last Name: \_\_\_\_\_ First (Legal): \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Address: \_\_\_\_\_ P.O. Box: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Sex: Male Female

**If Patient is Under 18 (Minor):** Responsible Party: Parent or Legal Guardian Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Ext.: \_\_\_\_\_

**Employment Information:** Is the Patient: Employed Self Employed Unemployed Retired Student  
Name of Employer/Business (Including Self Employment): \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Ext: \_\_\_\_\_

**Primary Care Physician:**  
Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Referring Physician:** (Self, Same or Requested Info)  
Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Social Status:** Is the Patient: Single Married Divorced Widowed Partner  
Spouse's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

**Emergency Contact:** Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Insurance Information:**  
**Primary Insurance:** \_\_\_\_\_ Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Patient Relation to Subscriber: Self Spouse Child  
Place of Employment: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Subscriber: \_\_\_\_\_ DOB: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Patient Relation to Subscriber: Self Spouse Child  
Place of Employment: \_\_\_\_\_

**All Patients: Authorization to Release Information & Assignment of Benefits**

I authorize the release of any medical information necessary to process my medical service claims, I permit a copy of this authorization to be used in place of the original. I hereby authorize Great Lakes Surgical Associates to apply for benefits on my behalf for covered services rendered by my physician. I request that any payments from my insurance company be made directly to Great Lakes Surgical Associates. I certify that the information I have reported with regard to my insurance coverage is correct. I understand that I am financially responsible for all charges whether or not they are paid by my insurer(s). I understand I can revoke this authorization at any time by submitting a written request. **I hereby state that all of the above information is valid and accurate to the best of my knowledge.**

Patient or Legal Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_