

FOOTHILLS SURGICAL ASSOCIATES, P.C.

Bruce Waring, M.D.
Elizabeth Brew, M.D.

Philip Neff, M.D.
Rebecca Wiebe, M.D.
Bryan Baer, M.D.

Rebecca Knight, M.D.
Christine Rogness, M.D.

PATIENT INFORMATION

_____ Date of Birth ____/____/____
Last Name First Name MI

_____ Street Address City State Zip Code

Please indicate Preferred method To reach you. (____) _____ Home Phone (____) _____ Cell Phone

(____) _____ Work Phone _____ Name of Employer

Social Security Number _____ - _____ - _____ Sex M F

Patient Status Single Married Separated Divorced Widowed Child

INSURANCE POLICY HOLDER OR SPOUSE INFORMATION:

_____ Date of Birth _____
Last Name First Name MI

Social Security Number _____ - _____ - _____ Work Phone (____) _____

_____ Occupation _____ Employer

Is Patient a Student? Yes No If Yes, Name of School _____

NEXT OF KIN In case of emergency, give the name of *nearest relative* or *close friend* not living with you.

Name _____ City _____ State _____

Home Phone (____) _____ Work Phone (____) _____ Relationship _____

PRIMARY CARE PHYSICIAN

Name _____ Phone (____) _____

REFERRING PHYSICIAN

Name _____ Phone (____) _____

INSURANCE INFORMATION

Does the Patient have Health Insurance? YES NO

Is this visit related to a work injury? YES NO If YES, Date of Injury: _____

Name of Insurance Contact Person (_____) Phone

Claim # Claims Mailing Address

Is this visit related to an automobile injury? YES NO If YES, Date of Accident: _____

Name of Insurance Contact Person (_____) Phone

Claim # Claims Mailing Address

Primary Health Insurance

Additional Health Insurance

Insurance Company

Insurance Company

Policy Holder

Policy Holder

Relationship to Patient: Self Spouse Child Other

Relationship to Patient: Self Spouse Child Other

ID/Policy #

ID/Policy #

Group #

Group #

Mailing Address

Mailing Address

City/State

City/State

PLEASE READ AND SIGN THE FINANCIAL POLICY OF FOOTHILLS SURGICAL ASSOCIATES, P.C. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN PROVIDED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. PLEASE CONTACT THE BILLING OFFICE TO ARRANGE PAYMENT OPTIONS OR TO DISCUSS ANY INSURANCE QUESTIONS AND/OR FINANCIAL/PAYMENT QUESTIONS YOU MAY HAVE.

I AGREE TO BE RESPONSIBLE FOR ALL PAYMENT OF SERVICES PROVIDED ON MY BEHALF OR MY DEPENDANTS. IT IS ULTIMATELY MY RESPONSIBILITY TO UNDERSTAND THE REQUIREMENTS AND PROVISIONS OF MY INSURANCE POLICY. IF A REFERRAL IS REQUIRED PRIOR TO SEEING A SPECIALIST, I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO OBTAIN ONE. THE UNDERSIGNED ASSIGNS ALL APPLICABLE INSURANCE BENEFITS/PAYMENTS TO THE PHYSICIAN/PROVIDER OF SERVICE. IT IS FURTHER UNDERSTOOD THAT THE UNDERSIGNED IS FINANCIALLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES THAT ARE NOT COLLECTED AS A RESULT OF THIS ASSIGNMENT. THIS ALSO APPLIES TO NON-COVERED SERVICES PROVIDED AND/OR THE ABSENCE OF INSURANCE COVERAGE AT THE TIME OF SERVICE. I AUTHORIZE FOOTHILLS SURGICAL ASSOCIATES, P.C. TO PROVIDE INFORMATION ABOUT MYSELF OR CHILD AND THE CARE GIVEN TO MY HEALTH INSURANCE COMPANY WHEN SUBMITTING REQUESTS FOR PAYMENT OF SERVICES PROVIDED TO MYSELF OR MY MINOR CHILD.

Patient/Parent of Minor or Authorized Person

Date