PLEASE FILL OUT FRONT AND BACK PAGE. SIGN AT ALL * STARRED AREAS AT BOTTOM OF PAGE ON BOTH SIDES

Patient Name:________________________ **PO Box Number if applicable:** ______________

Street Number & Name: ________________________ **City** ______________

State ________ **Zipcode** ____________ **Email Address:** ______________________

Phones: Home____________________ Work ______________ Cell ______________

Gender: Male or Female **Marital Status:** Married Single Divorced Widowed **SSN**: ______________

Circle One **Circle One**

Date of Birth: ___/___/_____ **Age** _____ **RACE:** White ___ Black ___ Hispanic ___ Asian ___ Indian ___ Other ______

Employer Name:________________________ Address:______________ Phone ______________

Referred By: ____________________ Primary Care Physician: ______________________

Emergency Contact: ______________ Relationship: ______________ Phone: ______________

Other Contact: ________________ Relationship: ______________ Phone:______________

Spouse's Name (If Applicable) ______________ **Date of Birth** __________ **SSN**______________

Spouse's Employer: ______________________________ Work Phone: ______________

BILLING INFORMATION

RESPONSIBLE PARTY (If other than patient) ____________________**Date of Birth**__________ **SSN**______________

Address ____ Phone ______________

Relationship to patient if patient is a minor (**Circle One**): Spouse Child Step Child Other ______________

Employer ________________ Work Phone ____________ Address ______________________

PATIENT MEDICAL HISTORY

Does the Patient **Smoke** __Yes __ **No** **How much per day?** __ **Drink Alcohol** __Yes __ **No** **How Often** ____________

Medication Allergies: ______________________________**Other Allergies:**______________

Current Medications: ____

Chronic Medical Problems, WHY are you taking the **medications** listed above ______________________

____

Previous Surgeries including C- Section, Tonsillectomy, dental surgery, eye surgery & etc. or See list:______________

____

Family History (list any significant problems including cancer, heart disease, diabetes, etc: ______________

____

INSURANCE INFORMATION (Please present cards to window to be copied)

Primary Insurance Company ____

Id#____________________Group#______________________ Copay Amt: ______________

Secondary Insurance Company ____

Id#____________________Group#______________________ Copay Amt: ______________

I assign all medical and/or surgical benefits from all insurance companies that I am involved with to Surgical Specialist of Bowling Green. I authorize the staff to release any information necessary to secure the proper payment. I authorize the release of any medical and/or billing information requested by a referred to and/or from physician or any other third party administrator (insurance company, medical facility, attorney, collection agency) at my or my physician/'staff request.

I DO AUTHORIZE TREATMENT AS RECOMMENDED

***PATIENT SIGNATURE** ______________________________ ***DATE:** ______________

Responsible Party Signature if Patient is a minor ________________________*DATE: ______________

I HAVE RECEIVED A COPY OF BG SURGICAL SPECIALIST FINANCIAL & PRIVACY POLICY SIGN & DATE BELOW.

***PATIENT INITIALS:**____________________ *** DATE OF INITIALS:** ______________

PATIENT CONSENT FORM

* **I, (Please Print) PATIENTS NAME**____

PATIENTS DATE OF BIRTH ____

Give permission to the following persons to receive any medical or financial information from the office of Surgical Specialist of Bowling Green, LLC, Michael Bielefeld, MD/Todd Tamlyn, MD. This would include the staff of the physician and hospital personnel if requested.

This is part of this offices HIPAA compliance

SPOUSE____

Others- Anyone we are allowed to give information to (Example-Children, Neighbor, Relative, Friend)

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We will leave a message for you on your answering machine/voice mail regarding a call to the office if needed or other general information unless otherwise advised by you. No test results or medical/financial information will be left in this manner.

***SIGNATURE**________________________________ *** DATE** ________________