

**ASSOCIATED COLON & RECTAL SURGEONS, P.A.
INFORMATION SHEET (PLEASE PRINT)**

DATE _____

NAME _____
FIRST LAST

ADDRESS _____
Street Town State & Zip Code

HOME PHONE # () _____ WORK/CELL # () _____

Please circle: Male/Female DOB _____ Age _____ SS# _____
Marital Status: S M W D Number of children _____

EMPLOYED BY: _____ OCCUPATION: _____

ADDRESS: _____
Street Town State & Zip Code

PRIMARY INSURANCE: _____ ID# _____

NAME OF INSURED: _____ DOB _____ SS# _____

RELATIONSHIP TO PATIENT: _____

INSURED'S EMPLOYER: _____

SECONDARY INSURANCE: _____ ID # _____

NAME OF INSURED: _____ DOB _____ SS# _____

RELATIONSHIP TO PATIENT: _____

INSURED EMPLOYER: _____

REFERRED BY (DOCTOR): _____
Name

ADDRESS _____ PHONE NUMBER _____

PRIMARY CARE (IF DIFFERENT FROM ABOVE): _____

ADDRESS: _____

I AUTHORIZE MEDICAL TREATMENT AND THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN FOR SERVICES RENDERED AND UNDERSTAND I AM RESPONSIBLE FOR ANY OUTSTANDING BANLANCE.

PATIENT/ GUARDIAN SIGNATURE