Chart # _____ Dr _____ Dr Requesting Consult _____

CENTRAL CAROLINA SURGERY, P.A.

PATIENT INFORMATION

First Name _____ Middle Name _____ Last Name _____

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Sex _____ Employed (Y / N / Retired / Student) Employer _____

Home Phone # _____ Work Phone # _____ Ext _____

Date of Birth_____ Soc Sec# _____ Marital Status: _____ Race _____

SPOUSE/GUARDIAN INFORMATION

First Name _____ Middle Name _____ Last Name _____

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Home Phone # _____ Work Phone # _____ Ext _____

Date of Birth_____ Soc Security # _____ Employed (Y / N / Retired / Student)

Employer _____ Relationship to Patient: _____

EMERGENCY CONTACT

Name _____ Relationship _____ Phone# _____

Name _____ Relationship _____ Phone# _____

Central Carolina Surgery is pleased to extend the courtesy of filing your insurance claim. Should you have an insurance that we are not contracted with, we ask that you make full payment at the time services are rendered. Any unmet deductibles, copayments or non-covered charges are to be paid at the time of check-out.

Authorization to Release Information: **I give permission to Central Carolina Surgery, P.A. to forward records (including, but not limited to, lab and x-ray reports, pathology reports and progress report(s) to any other doctor or agency involved in my care. I do hereby consent and authorize Central Carolina Surgery, P.A. to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics, which are part of my medical records. PLEASE NOTE: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information, as well as any information relating to pregnancy, sexually transmitted diseases, HIV testing, AIDS, and any AIDS-Related Syndromes. It also includes any information concerning Cancer, Cancer Testing, and Cancer results.**

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans to: Central Carolina Surgery, P.A. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will remain in effect.

(Patient Signature) (Date)

(Guardian/Power of Attorney) (Date)

PP