VR Surgical Associates, PA

Dr. Vincent A. Caldarola and Dr. Rachel Lovano
GENERAL SURGERY
COLON AND RECTAL SURGERY

DATE _____

PATIENT NAME _____ AGE _____ SEX _____

SOCIAL SECURITY# _____ TDL # _____ DATE OF BIRTH _____

MAILING ADDRESS _____ CITY_____ ZIP_____

E-MAIL:_____ 1ST PHONE#_____ 2ND PHONE #_____

PLEASE CIRCLE ONE:

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED OTHER

WORK STATUS: FULL-TIME PART-TIME RETIRED STUDENT NONE

RACE: AMERICAN INDIAN/ALASKA NATIVE / ASIAN / BLACK/AFRICAN AMERICAN / NATIVE HAWIIAN/OTHER PACIFIC / WHITE / REFUSE TO REPORT

ETHNICITY: HISPANIC or LATINO / NON HISPANIC or LATINO / REFUSE to REPORT

NATIONALITY: _____ ***LANGUAGE:*** _____

EMERGENCY CONTACT _____ RELATIONSHIP:_____

HOME NUMBER: _____CELL NUMBER: _____

PRIMARY INS. CO._____ INS. PHONE #_____

INSURED NAME_____ DOB:_____RELATIONSHIP _____

GROUP #_____ID #_____

SECONDARY INS. CO._____ INS. PHONE #_____

INSURED NAME_____ DOB:_____RELATIONSHIP _____

GROUP #_____ID #_____

PERSON RESPONSIBLE FOR PAYMENT: If information is the same as above, put SAME or SELF; for child, put Father's, Mother's or Guardian's name._____

REFERRED BY _____**(if doctor, please provide doctor's first name)**.

ASSIGNMENT OF INSURANCE BENEFITS TO PHYSICIAN: I request payment under the medical insurance program be made to **VR SURGICAL ASSOCIATES, PA.** I understand I am financially responsible to the physician for charges not covered by this authorization.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the above named provider of services to release information necessary for payment of this claim:

Signature _____ Date _____