

TOLEDO SURGICAL SPECIALISTS, INC.

Patient Information

First Name _____ Middle Initial _____ Last Name _____
Sex _____ Date of Birth ____/____/____ Social Security # _____ - _____ - _____
Street Address _____
City _____ State _____ Zip Code _____
Home Phone # _____ Work Phone # _____
Cell Phone # _____ E-Mail _____
Emergency/Other Contact & Phone # _____
Referring Physician, Address & Phone # _____
Primary Care Physician, Address & Phone # _____

If patient is a minor, who is the responsible party? _____
Are you a student? _____ Full Time _____ Part Time _____ No
Are you employed? _____ Full Time _____ Part Time _____ Retired _____ Not Employed
Employer Name, Address & Phone # _____

Is this a work related injury? _____ Yes _____ No If yes, date of injury _____
Marital Status _____ Spouse's Name _____
May we release your medical information to your spouse? _____ Yes _____ No

Primary Insurance Company _____
Insurance Company Address _____
Insurance Company Phone # _____ Co-Pay _____
Subscriber Name _____
Certificate ID _____ Group Name _____
Subscriber Date of Birth ____/____/____ Group # _____
Subscriber Social Security # _____ - _____ - _____ Relationship _____

Secondary Insurance Company _____
Insurance Company Address _____
Insurance Company Phone # _____ Co-Pay _____
Subscriber Name _____
Certificate ID _____ Group Name _____
Subscriber Date of Birth ____/____/____ Group # _____
Subscriber Social Security # _____ - _____ - _____ Relationship _____
Pharmacy Name _____ Pharmacy Phone # _____

I hereby authorize Toledo Surgical Specialists, Inc. (TSSI) to submit claims to my insurance carrier(s) for all services rendered by the physician(s). I authorize release of information necessary for these purposes. I authorize payment of medical benefits to TSSI for services rendered. I accept responsibility for payment of any deductible, co-insurance amount or co-pay according to the terms of my agreement with my insurance company and that said deductible, co-insurance or co-pay is due at the time of service.

_____	Information checked	Information checked
Patient Signature	by: _____	by: _____
	on: _____	on: _____
_____	Information checked	Information checked
Date	by: _____	by: _____
	on: _____	on: _____