

**PIEDMONT SURGICAL CLINIC
INFORMATION SHEET**

DATE: _____ (PLEASE CIRCLE) Marital Status: S M W D Sep (PLEASE CIRCLE) Sex: M F

FULL NAME _____ SS NO.: _____
FIRST MIDDLE MAIDEN LAST

ADDRESS OF PATIENT: _____
STREET OR ROUTE NO. AND BOX

CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ AGE: _____ HOME PHONE: _____ CELL PHONE: _____

(PLEASE CIRCLE) FATHER, MOTHER OR SPOUSE: _____ SS NO.: _____

I WILL PAY BY: CASH CHECK CREDIT CARD (VISA, MC)

EMPLOYMENT

PATIENT'S PLACE OF EMPLOYMENT: _____

EMPLOYER'S MAILING ADDRESS: _____

WORK PHONE NO.: _____

RESPONSIBLE PARTY IF NOT YOURSELF: _____

(PLEASE CIRCLE) FATHER, MOTHER OR SPOUSE'S PLACE OF EMPLOYMENT: _____

PHONE NO.: _____

EMERGENCY CONTACT

NAME OF NEAREST RELATIVE OR FRIEND, OTHER THAN ABOVE AND LIST A PHONE NO.: _____

REFERRED BY DR.: _____ PRIMARY CARE DR.: _____

WORKMEN'S COMPENSATION

Please complete this section thoroughly. It is very important if we are to file your claims for you.
If this visit concerns a job related accident, when was date of injury? _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____
NAME OF INSURANCE POLICY OR CERTIFICATE

POLICYHOLDERS NAME: _____ DATE OF BIRTH

SECONDARY INSURANCE: _____
NAME OF INSURANCE POLICY OR CERTIFICATE

POLICYHOLDERS NAME: _____ DATE OF BIRTH

OTHER INSURANCE: _____
NAME OF INSURANCE POLICY OR CERTIFICATE

POLICYHOLDERS NAME: _____ DATE OF BIRTH

AUTHORIZATION AND ASSIGNMENT

I hereby authorize G. Giltz Croley, II, M.D., Joseph P. Simpson, M.D., and their associate physicians to furnish protected health information(see our HIPAA Policies and Procedures) to my insurance carriers concerning my illness, treatment, and claim filing. I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I understand that if my account is past due and the services of a collection agency are used or a claim is filed with a county court in an attempt to collect this debt, I am solely responsible for the cost of such service.

DATE: _____ SIGNATURE _____

We invite you to discuss further with us any questions regarding our service or fees. The best medical service is based on friendly, mutual understanding between doctor and patient.

G. GILTZ CROLEY, II, M.D. JOSEPH P. SIMPSON, M.D. MICHAEL A. HOUSTON, M.D.