GRANTS PASS SURGICAL ASSOCIATES P.C.

1600 NW 6th St., North Suite
Grants Pass, Oregon 97526
Phone 541-474-5533
Fax 541-476-2380

PATIENT INTAKE FORM

PATIENT INFORMATION

Account _____

Social Security Number _____ Birth Date _____ Age _____

Name (Last) _____ First _____ Middle _____

Mailing Address _____ City _____ State _____ Zip _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced Sex ☐ F ☐ M

Primary Care Physician _____ Phone _____

Employer _____ Phone _____ Are calls allowed? ☐ Y ☐ N

Is your injury job related? ☐ Y ☐ N Workers Comp. Carrier _____

SPOUSE/PARENT INFORMATION

Name _____ Soc. Sec. No. _____

Employer _____ Phone _____ Are calls allowed? ☐ Y ☐ N

INSURANCE INFORMATION

If you have NO insurance, please check this box: ☐

How do you intend to pay? ☐ Insurance ☐ Cash ☐ Check ☐ Medicare ☐ Medicaid

Primary Insurance _____ Secondary Insurance _____

Address _____ Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

ID # _____ Group # _____ ID # _____ Group # _____

EMERGENCY CONTACT (other than Spouse/Parent)

Name _____ Relationship _____ Phone _____

Street Address _____ City _____ State _____ Zip _____

PLEASE READ, SIGN, AND RETURN TO THE RECEPTIONIST

I, the undersigned, authorize to Grants Pass Surgical Associates, P.C. by any insurance company that I have for all medical and surgical benefits, if any, otherwise payable to me for services rendered. I acknowledge that I am financially responsible for all charges whether or not paid by insurance, Medicare, and/or Medicaid. If it becomes necessary to effect collections, I agree to pay for all costs, including any reasonable attorney fees. I hereby authorize the doctor to release all information necessary to secure benefits.

I also understand that due to the cost of the ultrasound technician at least 24 hours advance notice is needed to cancel these appointments. FAILURE TO NOTIFY THIS OFFICE BY AT LEAST 24 HOURS PRIOR TO MY APPOINTMENT WILL RESULT IN MY BEING BILLED AN $85 FEE FOR THE TECHNICIAN.

Signature _____ Date _____