GRANTS PASS
SURGICAL
ASSOCIATES P.C.

Mark F. Deatherage, MD, FACS
Mark A. Jones, MD

# 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 ______
Address ______
City ______ State ______ Zip ______
ID # ______ Group # ______

Secondary Insurance ______
Address ______
City ______ State ______ Zip ______
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 ______

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