

# Waukesha Surgical Specialists, S.C. (WSS)

## PATIENT INFORMATION

PATIENT \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

SEX \_\_\_\_\_ SINGLE \_\_\_\_\_ MARRIED \_\_\_\_\_ WIDOWED \_\_\_\_\_ DIVORCED \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_ SPOUSE'S NAME \_\_\_\_\_

SPOUSE'S EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

REFERRED BY \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_

## INSURANCE INFORMATION

### PRIMARY INSURANCE:

NAME OF COMPANY \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SUBSCRIBER # \_\_\_\_\_ GROUP # \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_ INSURED'S BIRTH DATE \_\_\_\_\_

INSURED'S SOCIAL SECURITY # \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

### SECONDARY INSURANCE:

NAME OF COMPANY \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

SUBSCRIBER # \_\_\_\_\_ GROUP # \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_ INSURED'S BIRTH DATE \_\_\_\_\_

INSURED'S SOCIAL SECURITY # \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

**\* Please bring your insurance card(s) to your appointment for scanning.**

**EMERGENCY CONTACT:** Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Telephone \_\_\_\_\_

I hereby assign all medical/surgical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Waukesha Surgical Specialists, S.C. This order will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignment to release all information necessary to secure payment and to complete disability forms.

Signed \_\_\_\_\_ Date \_\_\_\_\_