TRI-COUNTY surgical PARTNERS
DAVID A. STONE, DO

PATIENT INFORMATION: Please fill out <u>completely</u>
INFORMATION DE PACIENTE: Por favor completo

- Patient Name: _____
  Nombre de paciente Last First Middle
- Referring/Family Doctor: _____
- Reason for Today's Visit: _____
- Age:_____ Date of Birth:_____ Soc. Sec.#: _____
  Edad Fecha de naciemento Seguro social
- M:___ F:___ Drivers Lic. #: _____ Marital Status: _____
  Hombre o Mujer Numero de licencia Soltero, Casado, Divorciado
- Home Address, City, State, Zip code:

  _____
  Direccion de Paciente, Ciudad, Estado, Codigo Postal
- Home Phone:_____ Cell Phone:_____
  Telephono de paciente Telephono celular
- Emergency Contact:_____ Tel. #: _____
  Nombre de persona de emergencia Numero de telephono
- Employer Name: _____
  Nombre de trabajo
- Employer Address, City, State, Zip code: Direccion de Paciente, Ciudad, Estado, Codigo Postal

  _____
- Work Phone: _____
  Numero de telephono
- Emergency Contact: _____ Tel. #: _____
  Nombre de Personal de Emergencia Numero de Telefono
- Name of the Insured (If other than patient): _____

  Date of Birth:_____ Soc. Sec. #: _____

  Employer:_____ Address: _____

  Work Phone: _____
- If Military: Active:____ Retired:_____ Deceased: _____ Branch:_____
- Military Sponsor:_____ Sponsor ID/SS #: _____

Patient Name: _____
Nombre de paciente:

FINANCIAL & PRIVACY POLICY:

- Charges for Medical Services are due and payable by the patient / guardian at the time of service (office visit). Co-payments, deductibles, and co-insurance are due at the time of service for all Healthcare plans that are accepted by this office, per plan.
- Charges for patients with insurance plans that we do not accept are due and payable in full at the time of service.
- The patient / guardian is responsible for all fees, regardless of insurance coverage.
    - You will be charged $35.00 for any checks returned by the bank.

I have read all of the above and request that all payments by my insurance carrier, including Medicare, to be paid directly to David A. Stone DO, PA. I also authorize the release of any medical or other information my insurance carrier necessary to process my claims.

Signature of Patient/Guardian:_____ Date: _____

My signature below acknowledges that I have received a copy of Tri-County Surgical Partners- David A. Stone DO PA's Privacy Policy. I have read and understand its contents and agree with all the terms and conditions stated above.

Signature of Patient/Guardian:_____ Date: _____

AUTHORIZATION OF RELEASE OF MEDICAL INFORMATION

I authorize release/disclosure of my Medical Information (Verbal and/or Written) to the following individuals:

1. _____ Relationship to the Patient: _____
2. _____ Relationship to the Patient: _____
3. _____ Relationship to the Patient: _____

Signature of Patient/Guardian:_____ Date: _____