Jay S. Orringer, M.D., F.A.C.S.

Date___________________

Patient's Name____________________________________ Referring Physician________________________

Address__________________________ City ________________________State________ Zip___________

Soc. Sec #__________________Marital Status_______ Sex_______ Date of Birth __________Age______

Resident Phone (   )__________________________ Cell phone/Pager______________________________

Patient's Employer___________________________ Address ______________________________________

Occupation ___________________________________Business Phone (   )__________________________

Spouse or Parent's Name ______________________ Relation to Patient ____________________________

Social security ________________________________Date of Birth _________________________________

Spouse or Parent's Employer __________________ Address _____________________________________

Occupation ___________________________________ Business Phone (   )__________________________

Who may we contact in case of emergency or if we need to change an appointment and cannot reach you?

Name ____Relationship__________________________________

Address ______________________________________ Phone (   )_________________________________

INSURANCE INFORMATION

INSURANCE COMPANY ______________________PHONE #___________________________________

CLAIMS ADDRESS___________________________ CITY________________________ZIP____________

INSURED'S NAME___________________________ INSURED'S DATE OF BIRTH ________________

POLICY #__________________________________ GROUP#___________________________________

INSURED'S EMPLOYER ______________________ ADDRESS __________________________________

SECONDARY INSURANCE ___________________PHONE #___________________________________

CLAIMS ADDRESS ___________________________CITY _______________________ZIP ____________

INSURED'S NAME ___________________________ POLICY #__________________________________

INSURED'S EMPLOYER ______________________ GROUP # __________________________________

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Jay S. Orringer, M.D. to release information requested by my Insurance Company or carrier. I also authorize Jay S. Orringer, M.D. to release any information to any Hospital or Physician I may be referred to by his Office or from whom I have been referred.

Signature:_______________________________________ Date:______________________

Relationship to Patient:____

ASSIGNMENT OF BENEFITS

I hereby authorize assignment of payment directly to Jay S. Orringer, M.D. for major benefits due me.

I HEREBY AGREE TO PAY ANY AND ALL CHARGES THAT EXCEED OR THAT ARE NOT COVERED BY INSURANCE.

Signature:______________________________________ Date:_______________________

Relationship to Patient:____

PHOTOGRAPHIC CONSENT

I grant permission for photographs of me to be taken and used for insurance and educational purposes.

Signature: ______________________________________ Date:_______________________

Relationship to Patient: ____

We request fees for Office Visits and Services at the time the service is rendered.