MIDWEST SURGICAL ASSOCIATES, PA
20375 W. 151st Street, Suite 463 Olathe, KS 66061
Telephone: 913-782-8577 FAX: 913-782-2616

Date: ______________________________

Who are you seeing today? ☐ Dr. Anderson ☐ Dr. Blake ☐ Dr. Davoren ☐ Dr. Jones ☐ Dr. Opie ☐ Dr. Paulsen

Who Referred You To Our Office? ______________________________ Primary Care Physician ______________________________

NAME ______________________________ (First MI Last) Soc Sec# _______-______-_______ Date of Birth _____/_____/_______

Street Address ______________________________ City ______________________ St ______ ZIP __________

Home Phone (_____)_________________ Cell Phone (_____)_________________ Gender: ☐ Male ☐ Female Age ______

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Patient's Occupation ______________________________

Patient's Employer ______________________________ Work Phone (_____)______________________

Spouse's Name (or Parent for Minor)______________________________ Spouse's (or Parent's) Date of Birth _____/_____/_______

Spouse's (or Parent's) Employer ______________________________ Spouse's (or Parent's) Work or Cell Phone(_____)____________

IS THE CONDITION WE ARE TREATING RELATED TO YOUR EMPLOYMENT? ☐ Yes ☐ No

Primary Insurance ______________________________ Relationship to Policy Holder: ☐ Self ☐ Spouse* ☐ Parent*

*If Policy Holder is Spouse or Parent, Please Make Sure All Information in the Above Section is Accurate and Complete.

WAS INSURANCE CARD PRESENTED AT VISIT? ☐ Yes ☐ No If no, please complete: Policy Number ______________________

Group Number ________________ Claims Address ______________________________

Secondary Insurance ______________________________ Relationship to Policy Holder: ☐ Self ☐ Spouse* ☐ Parent*

WAS INSURANCE CARD PRESENTED AT VISIT? ☐ Yes ☐ No If no, please complete: Policy Number ______________________

Group Number ________________ Claims Address ______________________________

ASSIGNMENT AND RELEASE / FINANCIAL RESPONSIBILITY

I hereby assign directly to Midwest Surgical Associates, P.A. all insurance benefits to include Medicare, Medigap, and any other insurance plan otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. A photocopy of this assignment is to be considered as valid as the original and will remain in effect until revoked by me in writing.

Signed ______________________________ Date: ______________________________

MEDICARE PATIENTS MUST ALSO COMPLETE THIS SECTION: LIFETIME CONSENT (AS REQUIRED BY MEDICARE)

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Midwest Surgical Associates, P.A. for any services furnished me by that group. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid (CMS) and its agents any information necessary to secure payment of benefits.

Signed ______________________________ Date: ______________________________