

JEFFREY T. PREM, M.D.

JOSEPH N. ZEMIS, M.D.

M. TODD MILLER, M.D.

REGIONAL SURGICAL SPECIALISTS, INC.

GENERAL • ENDOSCOPIC • LAPAROSCOPIC • VASCULAR

400 Medical Park Drive, Suite 203
Dover, Ohio 44622
Phone: 330-602-7702

1445 Harrison Avenue, Suite 103
Canton, Ohio 44708
Phone: 330-588-8900

PATIENT'S NAME: _____ DATE: _____
FIRST MIDDLE LAST

ADDRESS: _____
CITY STATE ZIP

SOCIAL SECURITY#: _____ BIRTH DATE: _____ AGE: _____ SEX: _____

MARITAL STATUS: S M W D

HOME PHONE: _____ EMERGENCY CONTACT NUMBER: _____

PATIENT'S EMPLOYER: _____ PHONE: _____

EMPLOYER'S ADDRESS: _____
CITY STATE ZIP

SPOUSE/GUARANTOR: _____

SOCIAL SECURITY#: _____ BIRTH DATE: _____

EMPLOYER: _____ PHONE: _____

EMPLOYER'S ADDRESS: _____
CITY STATE ZIP

COMPLAINT: _____ *Is this work related?* YES NO

REFERRING DOCTOR: _____ PHONE: _____

FAMILY DOCTOR: _____ PHONE: _____

PRIMARY INSURANCE

OTHER INSURANCE *Medicare Crossover?* YES NO

NAME: _____

NAME: _____

ADDRESS: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

CITY, STATE, ZIP: _____

PHONE: _____

PHONE: _____

SUBSCRIBER'S NAME: _____

SUBSCRIBER'S NAME: _____

POLICY #: _____

POLICY #: _____

GROUP NAME/NUMBER: _____

GROUP NAME/NUMBER: _____

IN ORDER TO SUBMIT AN INSURANCE CLAIM FOR SERVICES RENDERED, WE MUST HAVE YOUR AUTHORIZATION TO RELEASE INFORMATION TO YOUR INSURANCE CARRIER.

I verify the accuracy of the above information and hereby authorize the release of any information necessary to process a claim with my insurance company. I authorize payment of medical benefits paid directly to Regional Surgical Specialists, Inc. **I understand that I am financially responsible for any charges incurred regardless of insurance coverage.** This signature is valid until revoked by me in writing.

SIGNATURE: _____ DATE: _____

Office visits are due and payable at the time of service unless you have Medicare or we participate with your insurance plan. If we do participate with your carrier, you are responsible for your co-payment at the time of service. If your insurance requires a written authorization from your primary care physician, please provide this prior to your appointment