Cascade Surgical Partners

Date:___________________________
Account Number:________________

PATIENT INFORMATION

First Name_____________________MI____Last Name__________________
Address_____________________________Mailing______________________
City________________________________State______________Zip_______
Telephone_____________________Birthdate______________Sex_________
SS#_____________________________Spouse's Name__________________
Employer______________________________Work Phone________________
Do you have a cell phone we may call?________________________________
Emergency Contact (please list someone who does not live with you)
Name________________________Phone____________Relationship_______
Name of Doctor who referred________________Family Doctor____________

GUARANTOR INFORMATION

(Please fill this information out if patient is a minor)

First Name_______________Last Name______________Relationship______
Address (If Different from above)____________________________________
City_____________________________State__________Zip_____________
Telephone_________________________Cell Phone______________________
SS#__________________________Birthdate__________________Sex_______
Employer___________________________Work Phone___________________

Please Note: You are responsible for the payment of this account. We will, however, routinely bill your insurance for you if you provide you with that information. If you have any questions regarding your bill, please ask to speak with someone in our Billing Department.

I hereby authorize Dr. Bernfeld/Dr. Conroy/Dr. Kisala/Dr. Young to release any information required by my insurance company in order for payment of my account. I hereby assign to the doctor all the money to which I am entitled for medical and/or surgical expenses for my services received.

Patient or Guardian
Signature____