JEFF L. JOHNSON, MD, PA

GENERAL & LAPAROSCOPIC SURGERY

PATIENT INFORMATION

Last Name: _____ First Name:_____ Middle Initial:_____

Address: _____Apt#: _____ City: _____State:_____ Zip:_____

Home#: _____ Work#: _____ Cell#: _____

Age: _____ Sex: M F Date of Birth: _____ Marital Status: _____ SS#:_____

Employer's Name: _____ Occupation: _____

Address: _____City/State :_____Zip:_____

EMAIL ADDRESS:_____

EMERGENCY CONTACT:_____ Relationship: _____ PHONE _____

Pharmacy:_____Pharmacy Phone #_____

INSURANCE INFORMATION – Please provide insurance cards for us to copy

If the patient's insurance requires a referral from the PCP to see a specialist and if the patient does not have a valid referral at the time of the appointment, we will offer to reschedule the appointment until a referral is obtained or see the patient on a self pay basis.

PRIMARY Insurance: _____ ID #:_____Group#:_____

Name of Policy Holder: _____ Date of Birth: _____ SS#: _____ Relationship to Patient _____

SECONDARY Insurance: _____ ID #:_____ Group#:_____

Name of Policy Holder: _____ Date of Birth: _____ SS#:_____ Relationship to Patient: _____

PRIMARY CARE PROVIDER: _____ Phone:_____

Name of Preferred Laboratory if applicable:_____

Assignment and Authorization of Benefits

I hereby give authorization for payment of insurance benefits to be made directly to Jeff Johnson MD, PA for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In event of default, I agree to pay all costs of collection and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this Agreement is as valid as the original.

Authorization for Email & Voicemail Usage for PHI

- **I hereby give permission to leave a message on my voicemail concerning my personal health information** ☐ **(decline option)**
- **I hereby give permission to communicate, via email address listed above, my personal health information** ☐ **(decline option)**

I further understand that this permission to communicate my personal health information will remain in effect until I request, in writing, to have this option of communication terminated.

_____

_____

Patient Signature **Date** **Witness Signature**
Date