GERIG SURGICAL ASSOCIATES, P.C.

2006 South Main Street, Suite A, Goshen, IN 46526
Phone: 574.535.9100 Fax: 574.535.1020

NATHANIEL T. DEW, MD, FACS DANIEL A. DIENER, MD, FACS KEVIN D. GERIG, MD, FACS WINSTON D. GERIG, MD, FACS
JOHN C. MARTENS, MD, FACS DENISE C. MURPHY, MD, FACS MARK R. RANZINGER, MD, FACS KRISTAN M. RHEINHEIMER, FNP-BC

**PLEASE PRINT**

First Name________________________________Last______________________________MI__________

Street Address________________________________City____________________State________Zip__________

Home Phone (____) _____________Cell Phone (____) _____________**Email Address**________________________

SSN#_______/_______/_______Date of Birth_______/_______/_______Age________Sex________Marital Status_________

**Preferred Language** (*If other than English*)__________________________**Race/Ethnicity** (*Circle all that apply below*)

Caucasian Black Hispanic Asian Native American Pacific Islander American Indian Native Hawaiian Other Unknown Refused

**Patient's Employer**______________________________________________________________

Work Phone (____) ____________________Ext.________Occupation ____________________________

**Responsible Party Name** (*If not patient*)__________________________Relationship__________________

Mailing Address________________________________City____________________State________Zip__________

Home Phone (____) _______________Work Phone (____) _______________Cell Phone (____) _______________

**Emergency Contact Name**______________________________Relationship______________________________

Home Phone (____) _______________Work Phone (____) _______________Cell Phone (____) _______________

**Referring Dr.** ______________________________ **Family Dr.**______________________________
*First Name* *Last Name* *First Name* *Last Name*

**Pharmacy Name**____________________________**Location**____________________________________

**Nursing Home Name**______________________________ Nursing Home Phone (____) __________________

I authorize the release of my medical information/records to the following person/people:

**Contact Name**____________________________________Relationship____________________________

**Contact Name**____________________________________Relationship____________________________

**INSURANCE INFORMATION**

**Primary** Insurance Company Name________________________________________________________

Policy Holder's Name (**If other than patient**) ______________________________________________
*First Name* *MI* *Last Name*

SSN#______/______/______Date of Birth______/______/______ Relationship to Patient______________________

Employer________________________________ Work Phone (____) _________________ext.____________

**Secondary** Insurance Company Name

Policy Holder's Name (**If other than patient**)
*First Name* *MI* *Last Name*

SSN#______/______/______Date of Birth______/______/______ Relationship to Patient______________________

Employer Work Phone ( ) ext.

***Insurance cards and photo ID must be provided at time of visit.***

I hereby authorize Gerig Surgical Associates, P.C. to furnish information to insurance carriers concerning my illness and treatments, and I hereby assign to the physicians all payments for medical services rendered to myself or dependants. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services. If item 12 of the HCFA-1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown. I understand that I am responsible for balances due to deductibles, co-insurance, or non-covered services.

**Signature**__________________________________________________**Date**____________________