Bay Area Physicians Surgery Center

6043 Winthrop Commerce Ave
Riverview, FL 33578
(813)699-1200
(813)699-1201 *fax*

Patient Information **Date**:_______________________

Patient_______________________________ Sex (__)F (__)M DOB___/___/___

Marital Status_____________ SS#_________________ Home Phone (__) ___________________

Address_____________________________________City_______________State____ Zip____________

Employer______________________________ Work Phone (__) __________ Cell Phone (__)_________

Patient under 18yr (__) Yes (__) No If yes:

Responsible Guarantor_________________________ Sex (__)F (__)M DOB___/___/___

Marital Status_____________ SS#________________ Home Phone (__) __________________________

Address_____________________________________City_______________State____ Zip____________

Employer_____________________________ Work Phone (__) ___________ Cell Phone (__)__________

Emergency Contact Person_______________________ Relation______________ Phone (__)_________

Insurance Information

Primary_____________________ Policy #____________________ Subscriber _____________________

Secondary___________________ Policy #____________________ Subscriber _____________________

Policy Holder

Name_________________________ Sex (__) F (__) M DOB___/___/___

Relation to Patient____________ SS#_________________ Home Phone (__)______________________

Address_____________________________________City_______________State____ Zip___________

Employer______________________________ Work Phone (__) ___________ Cell Phone (__)________

I authorize **BAPSC** to release any information pertaining to my medical record and/or any Billing disputes to the following person(s):_____________________________ Relationship to Pt:________________________

Name: ____ Relationship to Pt: ________________________

Authorization of Treatment and Assignment of Benefit

I authorize *Bay Area SC* to treat me. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to *Bay Area SC* for all medical or surgical benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all co-payments and any charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

Patient / Guardian Signature__________________________________ Date______________________

Printed Name____