

**This form must be completed in full
Cary Surgical Specialists, PC**

Patient Last Name		Patient First Name		Middle Initial	Male _____ Female _____
Date of Birth	Patient's Social Security Number	Home Number	Work Number	Cell Number	
Mailing Address		City	State	Zip	
Home Address If Different					
Referring Physician (Dr's first and last name)		Address		Phone Number	
Primary Care Physician (Dr's first and last name)		Address		Phone Number	
Patient's Employer		Phone Number			
Spouse's Name		Spouse's Employer		Spouse's work Number	
Emergency Contact		Relationship		Phone Number	
Guarantor (Person responsible for bill)		Date of Birth		Social Security Number	
Address of Guarantor					
Primary Insurance		Name of Policy Holder		SS# of Policy Holder	
Date of Birth of Policy Holder		ID# on Policy		Policy Group #	
Policy Holder Employer					
Secondary Insurance		Name of Policy Holder		SS# of Policy Holder	
Date of Birth of Policy Holder		ID# on Policy		Policy Group #	
Policy Holder Employer					
Workman's Compensation? (Circle One)		Yes No			

Full payment is due at the time of service. I agree to be responsible for my expenses. I authorize my insurance company, attorney or any other parties to pay Cary Surgical Specialists, PC. directly and provide any information regarding payment of my medical charges. I accept responsibility for any balance due and any items not covered by my insurance company. I authorize the physician to administer medical care as is necessary.

Signature: _____ Date _____