

**DR. JEFF JOHNSON, MD
DR. LAUREN ASH, MD
General and 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