CENTRAL OHIO GENERAL SURGEONS Phone 740.654.6213 or 800.819.3100 Fax740.654.3346

SECTION 1 – PATIENT INFORMATION

LAST NAME	FIRST NAME		MI	SOCIAL SECURITY NUMBER
ADDRESS	CITY	STATE	ZIP	HOME PHONE#
DATE OF BIRTH / AGE	GENDER M/F	MARITAL STATUS		CELL PHONE #
EMPLOYER	EMPLOYER ADDRESS			WORK PHONE #
EMERGENCY CONTACT	RELATIONSHIP			EMERGENCY CONTACT PHONE#
FAMILY DOCTOR	PREFERRED PHARMACY			PHARMACY PHONE #

SECTION 2 – RELEASE OF MEDICAL INFORMATION

I GIVE PERMISSION FOR MY MEDICAL INFORMATION TO BE DISCUSSED WITH:
(**NAME** of spouse, parent, child, caregiver, etc.)

_____
First Name **Last Name**
(Patient's responsibility to make any changes.)

May we leave a message at home with other residents?
[ ] Yes [ ] No

EMAIL:_____

Is today's visit work related?
[ ] Yes [ ] No

If yes, date of injury:

SECTION 3 – INSURANCE

PRIMARY INSURANCE	ID # / POLICY #	GROUP # / PLAN #
CARDHOLDER'S NAME **(IF DIFFERENT THAN PATIENT)**	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NUMBER
CARDHOLDER ADDRESS **(IF DIFFERENT THAN PATIENT)**	PHONE	DATE OF BIRTH
EMPLOYER NAME & ADDRESS		EMPLOYER PHONE
SECONDARY INSURANCE	ID # / POLICY #	GROUP # / PLAN #
CARDHOLDER'S NAME **(IF DIFFERENT THAN PATIENT)**	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NUMBER
CARDHOLDER ADDRESS **(IF DIFFERENT THAN PATIENT)**	PHONE	DATE OF BIRTH
EMPLOYER NAME & ADDRESS		EMPLOYER PHONE

SECTION 4 – AUTHORIZATION AND RELEASE:

1. I hereby authorize the health providers of Central Ohio General Surgeons (COGS) to examine me or my dependent above. **COGS may release or obtain any pertinent information or medical records listed necessary for continuity of care or reimbursement from my insurance carrier.**
2. I also authorize benefits to be paid directly to COGS and acknowledge that I am ultimately responsibility for all charges that my insurance does not cover.
3. I have read and understand the COGS financial policy and should my account become delinquent, I authorize COGS and their representatives to access my credit bureau report.
4. It has been explained to me as a requirement of CMS that I am entitled to receive a copy of COGS's privacy statement concerning my PHI. This has also been posted in the waiting area for my review. I acknowledge this right and will contact a staff member of COGS if I wish to receive a copy of this statement.
5. I have received a copy of COGS's narcotics prescribing policy and understand that violation of these guidelines may result in discharge from the practice.
6. For identification purposes, I authorize COGS to capture my photo upon check-in.

****You must be the parent or legal guardian to sign for a minor child.****

_____ / /
SIGNATURE *I am (circle one)*: **patient / parent / guardian / POA** **DATE**

_____
RELATIONSHIP TO PATIENT