Southeastern Surgical Associates, PC

Southeastern Vascular Laboratory

100 Camp Street
Hyannis, MA 02601
508-775-1984

Name ______________________________ Marital Status __________ Sex ______ Date ___/___/___
Last First MI (S M W D) M/F

Mailing Address ______________________________
Street City Zip

Telephone ( ) - Cell ( ) - DOB / / SSN# - -

E-mail ______________________________

Employer ______________________________ Occupation ______________________________

Employer's Address ______________________________ Telephone ( ) -
Street City Zip

Emergency Contact

Name ______________________________ Relationship ______________________________
Last First MI

Address ______________________________ Telephone ( ) -
Street City Zip

Primary Care Physician ______________________________ Referring Physician ______________________________

Billing Information

Insurances ______________________________
Company Name(s) Policy Holder Policy Number

Insurances ______________________________
Company Name(s) Policy Holder Policy Number

Billing Information of Policy Holder/Subscriber (*If different than patient*)

Name ______________________________ DOB / / Relationship ______________________________
Last First MI

Address ______________________________ Telephone ( ) -
Street City Zip

Insurance Authorization and Assignment

I hereby authorize the physicians of Southeastern Surgical Assocaites, PC to furnish information to insurance carriers concerning my illness and treatments and hereby assign to the physician(s) all payments for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance.

Signature ______________________________ Date / /

ALL MEDICARE RECIPIENTS PLEASE SIGN BELOW

I request that payment of authorized Medicare benefits be made to me or on my behalf to Southeastern Surgical Associates, PC for any services furnished me by that physician. I authorize any holderof medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services

Signature ______________________________ Date / /