



**GENESEE
SURGICAL
ASSOCIATES**
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NEW PATIENT INFORMATION

PLEASE COMPLETE USING BLACK INK

APPOINTMENT DATE _____

PATIENT NAME: _____ SEX: M F MAIDEN NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE HOME: _____ WORK: _____ CELL: _____ MARITAL STATUS: M S W D

BIRTHDATE: _____ SOCIAL SECURITY #: _____

RACE: White African Amer Asian Hispanic Other: _____ PRIMARY LANGUAGE _____

EMPLOYER: _____ ADDRESS: _____ OCCUPATION: _____

SPOUSE/PARTNER OR PARENT/GUARDIAN NAME: _____ RELATIONSHIP _____

PRIMARY CARE PHYSICIAN: _____ **PHONE#:** _____

****PHARMACY USED:** _____ **LOCATION:** _____

INSURANCE INFORMATION: ******Copays are due at the time of service******

PRIMARY: NAME OF INSURANCE COMPANY: _____

INSURANCE ID#: _____ SUBSCRIBERS NAME: _____

BIRTHDATE: _____ SOCIAL SECURITY #: _____ RELATIONSHIP: _____

SECONDARY: NAME OF INSURANCE COMPANY: _____

INSURANCE ID# _____ SUBSCRIBERS NAME: _____

BIRTHDATE: _____ RELATIONSHIP: _____

ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

I certify that the above information is correct. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event my insurance carrier makes payment directly to me I will endorse such payments to Genesee Surgical Associates, P.C.. I authorize my insurance carrier to release information regarding my coverage to Genesee Surgical Associates, P.C.. I authorize Genesee Surgical Associates, P.C. to obtain and/or release any medical records necessary to my physician(s), attorney(s), insurance company(s), including Medicare and/or their representatives. I also authorize payment of medical benefits directly to my physician and agree to accept responsibility for any charges denied by my insurance company. It is understood and agreed that in the event any outstanding balance has to be referred to a collection agency or attorney for recovery, I will be fully responsible for all collection agency fees and attorney's fees. This agreement/authorization will remain in effect unless revoked by me in writing. I have read this and accept the terms. A copy of this may be used in place of the original.

Signature of patient or authorized person (if other than patient, indicate relationship to patient)

Date

NOTE: Genesee Surgical Associates, P.C. is **not** responsible for any lost or stolen belongings. There is a **\$30.00** service fee for any returned checks.