John H. Alexander, M.D., F.A.C.S.
General Surgery – Bariatric Surgery

PATIENT INFORMATION

TODAY'S DATE: _____ / _____ / _____

PATIENT NAME:_____ _____
LAST FIRST MI MARTIAL STATUS

ADDRESS: _____ _____
STREET APT# CITY STATE ZIP

WORK #: (_____) _____ **HOME#:** (_____) _____
EXTENTION

SS#: _____ **CELL#:** (_____) _____

SEX: ☐ **MALE** - ☐ **FEMALE** **DOB**: _____ / _____ / _____ **AGE**: _____

EMPLOYER: _____ **OCCUPATION**: _____

ADDRESS: _____ _____ _____ _____
STREET SUITE CITY STATE ZIP CODE

EMAIL ADDRESS: _____
(PLEASE PROVIDE US WITH YOUR EMAIL ADDRESS SO THAT WE MAY SEND YOU OUR MONTHLY NEWSLETTER AS WELL AS OTHER HELPFUL INFORMATION.)

IF APPLICABLE: SPOUSE'S NAME: _____ **SS#**: _____

DOB: _____ / _____ / _____ **EMPLOYER**: _____ **WORK#**: (_____)_____

COMPLETE IF PATIENT IS UNDER 18 YEARS OF AGE

FATHER'S NAME: _____ **DOB**: ____ / ____ / ____ **WORK#**: _____ **SS#**:_____

MOTHER'S NAME: _____ **DOB**: ___ / ____ / ____**WORK#**: _____**SS#**:_____

FINANCIAL / INSURANCE INFORMATION

Office services are to be paid at the time rendered, unless prior arrangements have been made.
Payment preference: ☐ Check, ☐ Cash, ☐ M/C, VISA, Am, Express.

Please provide driver's license and insurance I.D. cards(s), we will retain a file copy to expedite processing of your benefits. Thank You!
☐ **No Insurance** ☐ **Individual** ☐ **Group** ☐ **PPO** ☐ **POS** ☐ **HMO/EPO** ☐ **Medicare** ☐ **Medicare Secondary** ☐ **Champus** ☐ **Work Comp.**

Insurance Company: _____ **Phone #:** _____

Insured: _____ **DOB**: ____ / ____ / ____ **I.D.** _____**Group/Policy**: _____
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child **Other**: _____

Please review, and sign authorizations below for medical claim processing. 30-45 days extended for coordination of benefits, you will be billed or any unpaid co-insurance, deductible, non-covered, or denied services under the terms of your policy.
I hereby acknowledge and consent to treatment by Dr. Alexander or providers working for Dr. Alexander. **Initial:** _____

RELEASE OF MEDICAL INFORMATION
I authorize the release of any medical information necessary to process this claim.
I also request payment of government benefits either to myself or to the party who accepts assignments.

ASSIGNMENT OF BENEFITS
I authorize payment of medical benefits to John H. Alexander, M.D.
↓

Signed: _____ **Date**: _____ **Signed**: _____

IMPORTANT! Please list allergies to medications: _____

Who referred you to Dr. Alexander? _____

Reason for which you are seeing Dr. Alexander: _____
Date symptoms first occurred: _____ **Injury related?** ☐ Yes ☐ No ☐ Work related ☐ Auto ☐ Other