CENTER OF SURGICAL EXCELLENCE

T. J. Khan, MD, FACG **J. J. Khan, MD**
8421 Pointe Loop Drive, Venice, FL 34293 * Phone 941-412-9787 * Fax 941-480-0388
www.surgeryvenice.com

Patient Information:

Patient Name: _____ Age: _____ Marital Status: S M W D

DOB: _____ Sex: M F SS#: _____

Address: _____ City: _____ State:____Zip: _____

Northern Address: _____ City: _____ State:____Zip: _____

Home Phone: _____ Cell: _____ Work: _____

Spouse Name: _____ Age: _____ DOB: _____

Spouse's SS#: _____

Referring Physician: _____

Pharmacy: _____ Phone #: _____

Emergency Contact: _____

Relation to Patient: _____ Phone #: _____

Insurance Information:

Primary Insurance:_____ Policy ID #: _____

Policy Holder's Name: _____ DOB: _____ SS#:_____

Secondary Insurance: _____ Policy ID#: _____

Policy Holder's Name: _____ DOB: _____ SS#:_____

All professional services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the PATIENT is responsible for all fees. It is customary to pay for services, co-payments, deductibles when services are rendered unless other arrangements have been with our office in advance.

INSURANCE AUTHORIZATION

I request that payment of primary and authorized Medigap benefits are made on behalf of G.A.V.E for any services furnished to me by the physician. I authorize any holder of medical information about me to release to G.A.V.E or C.O.S.E any information needed to determine these benefits payable for related services.

Signature: _____ Date: _____