Michael F. Scheer, M.D., F.A.C.S. Daniel A. Liesen, M.D., F.A.C.S. Amit Parikh, D.O.

Thank you for selecting our healthcare Team! We will strive to provide you with the best possible care.
To help us meet all your healthcare needs, please fill out this form completely.
Your Driver's License and Social Security number is required in order to determine identity. It is the policy of our practice to implement an Identity Theft Prevention Program to detect, prevent and mitigate identity theft in connection with new and existing patient accounts.

Drivers License # _____

Patient Information *(CONFIDENTIAL)*

Soc. Security # _____

Last Name _____ *First Name* _____ *MI* _____
Address _____ *City* _____ *State* _____ *Zip Code* _____
Date of Birth _____ *Sex* _____ ***Phone#***_____ *Marital Status* _____
Race: _____ *Language Preference:* _____
Pharmacy Preference and Location: _____
*Occupation*_____ ***Cell Phone #***_____*Email:* _____
Patient's Employer _____ *Work #* _____
Work Address _____ *City, State, Zip* _____
Spouse or Parent's Name _____ *Employer* _____ *Work #*_____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency:
_____*Phone #* _____*Relationship:* _____

Name of Family Physician_____

Insured Information

Relationship to
*Name of insured*_____ *Patient* _____
Address _____ *Phone#*_____
City _____ *State* _____ *Zip Code* _____
Birthdate _____ *Soc. Sec. #* _____ *Work #* _____
Employer _____

Primary Insurance

HMO ____ *PPO* _____ *POS* _____ *Workman's Comp* ____ ***Co-pay amt.***$_____
Insurance Company _____*Group #* _____
Policy / I.D. # _____*Phone #* _____
Address _____ *City* _____*State* _____ *Zip* _____
If Workers Compensation: *Date of Injury* _____ *Contact Person:* _____
Phone # _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ( ) YES ( ) NO If yes, complete the following
Name of Insured _____ *Relationship to Patient* _____
Birthdate _____ *Soc. Sec. #* _____ *Employer* _____
Insurance Company _____ *Group #* _____
Policy / I.D. # _____ *Phone #* _____
Address _____ *City* _____ *State* _____ *Zip*_____

Financial Arrangements: *For your convenience, we offer the following methods of payment. Please check the option which you prefer. Payment is expected at the time of service unless other arrangements have been made with our office.*
_____ ***Cash*** _____ ***Personal Check*** _____ ***Visa*** _____ ***MasterCard***

Authorization and Release

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize you to release and to receive any medical information to those you deem necessary. I hereby authorize my insurance company to pay directly to Scheer & Liesen Surgical Associates benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____/_____
Signature of patient or parent if minor Date

(Please turn page over)