

**REGIONAL SURGICAL SPECIALISTS, INC.**

GENERAL • ENDOSCOPIC • LAPAROSCOPIC • VASCULAR

400 Medical Park Drive, Suite 203  
Dover, Ohio 44622  
Phone: 330-602-7702

1445 Harrison Avenue, Suite 103  
Canton, Ohio 44708  
Phone: 330-588-8900

PATIENT'S NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
FIRST MIDDLE LAST

ADDRESS: \_\_\_\_\_  
CITY STATE ZIP

SOCIAL SECURITY#: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: \_\_\_\_\_

MARITAL STATUS: S M W D

HOME PHONE: \_\_\_\_\_ EMERGENCY CONTACT NUMBER: \_\_\_\_\_

PATIENT'S EMPLOYER: \_\_\_\_\_ PHONE: \_\_\_\_\_

EMPLOYER'S ADDRESS: \_\_\_\_\_  
CITY STATE ZIP

SPOUSE/GUARANTOR: \_\_\_\_\_

SOCIAL SECURITY#: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ PHONE: \_\_\_\_\_

EMPLOYER'S ADDRESS: \_\_\_\_\_  
CITY STATE ZIP

COMPLAINT: \_\_\_\_\_ *Is this work related?* YES NO

REFERRING DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

FAMILY DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

PRIMARY INSURANCE

OTHER INSURANCE *Medicare Crossover?* YES NO

NAME: \_\_\_\_\_

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

PHONE: \_\_\_\_\_

PHONE: \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_

POLICY #: \_\_\_\_\_

POLICY #: \_\_\_\_\_

GROUP NAME/NUMBER: \_\_\_\_\_

GROUP NAME/NUMBER: \_\_\_\_\_

**IN ORDER TO SUBMIT AN INSURANCE CLAIM FOR SERVICES RENDERED, WE MUST HAVE YOUR AUTHORIZATION TO RELEASE INFORMATION TO YOUR INSURANCE CARRIER.**

I verify the accuracy of the above information and hereby authorize the release of any information necessary to process a claim with my insurance company. I authorize payment of medical benefits paid directly to Regional Surgical Specialists, Inc. **I understand that I am financially responsible for any charges incurred regardless of insurance coverage.** This signature is valid until revoked by me in writing.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Office visits are due and payable at the time of service unless you have Medicare or we participate with your insurance plan. If we do participate with your carrier, you are responsible for your co-payment at the time of service. If your insurance requires a written authorization from your primary care physician, please provide this prior to your appointment