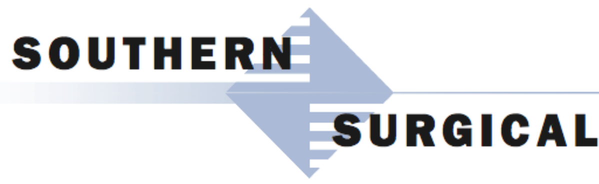

Wade Naziri, MD William Chapman, MD Julie Johannes, PA-C

PATIENT INFORMATION

LAST NAME	FIRST NAME		MI
STREET ADDRESS	CITY	STATE	ZIP
MAILING ADDRESS (if different)	CITY	STATE	ZIP
SOCIAL SECURITY #	DATE OF BIRTH	RACE	
MARITIAL STATUS **M S D W**	ETHNICITY *Non Hispanic/Hispanic/Decline*		
SEX **M F**	PREFERRED LANGUAGE		
HOME PHONE	WORK	CELL	
EMPLOYER	MAY WE CONTACT YOU AT WORK? **Y N**		
EMAIL	PREFERRED CONTACT: **HOME | CELL | EMAIL | PORTAL**		

EMERGENCY CONTACT INFORMATION

LAST NAME	FIRST NAME	MI
RELATIONSHIP	PHONE	

PRIMARY CARE PHYSICIAN

Name	Did they refer you? **Y N**
Address	Phone

PHARMACY

Preferred Pharmacy	May we electronically import your medications? **Y N**
Address	Phone

INSURANCE INFORMATION

PRIMARY INSURANCE	INSURED NAME	
Social Security#	Date of Birth	Relationship to Patient
ID#	GROUP#	

PLEASE PRESENT RECEPTIONIST WITH YOUR INSURANCE CARD

SECONDARY INSURANCE	INSURED NAME	
Social Security#	Date of Birth	Relationship to Patient
ID#	GROUP#	

YOUR CO-PAY IS DUE AT THE TIME OF SERVICE. THANK YOU!

Do you have or expect to have Medicare? **Y N**

I hereby authorize my benefits to be paid directly to Southern Surgical Associates, PA realizing that I am responsible to pay non-covered services. I also authorize the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I hereby give consent to healthcare providers of Southern Surgical Associates, PA to evaluate and render medical treatment.

SIGNATURE: *DATE:*

PRIVACY PRACTICE ACKNOWLEDGEMENT/CONSENT TO CALL

I have received the Notice of Privacy Practices and have been provided the opportunity to review it. I understand that Southern Surgical may send me messages via email, text or by phone.

SIGNATURE: *DATE:*

HOW/WHO DID YOU HEAR ABOUT SOUTHERN SURGICAL FROM SO WE MAY THANK THEM?