Beaumont

Acute Care Surgery
General Surgery New Patient Paperwork
Dr. Peter Perakis, Dr. Kerry Kole and Dr. Patricia Pentiak

Patient Information Date: ________________

Name: ____ Birth Date: _____/_____/_____

Social Security No: _______________________

Address: _____________________________ City: _________________ State: ______ Zip: ________

Home Phone: ________________________ Cell Phone: ____________________

Sex: Male Female

How did you hear about us? Friend / Family Beaumont Website Newspaper Ad Beaumont Referral Beaumont E.R.

Primary Insurance: (Please present Insurance Card and Driver's License (or proper picture ID) at the time of your visit, if you cannot provide proper identification, your appointment may be delayed or rescheduled)

Insurance Name: ______________________________ Effective Date: ___________________

ID/Contract No: __________________________ Group No: ______________________

Policy Holder: ____________________________ Relationship to Patient: __________________

Subscriber Birth Date: _____/_____/_____ Employer: ___________________________________

Secondary Insurance:

Insurance Name: ______________________________ Effective Date: ___________________

ID/Contract No: __________________________ Group No: ______________________

Policy Holder: ____________________________ Relationship to Patient: __________________

Subscriber Birth Date: _____/_____/_____ Employer: ___________________________________

Have you or anyone in your immediate family traveled outside of the United States in the past 30 days? Yes____ No____

Emergency Contact: Name: ___________________________________Phone: _________________________

Relationship: ___________________

I understand that it is my responsibility as a patient to know my own insurance. I understand that there may be charges that my insurance plan will not pay, and I agree to pay Beaumont Acute Care Surgery for any and all services rendered in its entirety.

____ ___________________
(Patient Signature) (Today's date)

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Patient Name: ____ Date of Birth: _____/_____/_____

List of current medications: (If you have a current list, please present it to the office and you may skip this section and proceed to below Allergies)

Name	Strength	Directions
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

List all allergies:

Allergies	Reaction
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

*Please attach a separate sheet if necessary for any additional information

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Acute Care Surgery
44199 Dequindre Road, Suite 315
Troy, MI 48085
Office: 248-964-1180
Fax: 248-964-1188

Dear Patient:

To allow patients access to timely medical care, we require that you call us at least 24 hours prior to your scheduled appointment if it needs to be cancelled or rescheduled.

Effective **1/1/2015**, we will be charging a fee of $**20.00** for any appointment that is missed without calling to cancel or reschedule within **24 hours** of the scheduled appointment time.

Signed,

Acute Care Surgery

I, ______________________________________, acknowledge this policy within Acute Care Surgery– Beaumont Medical Group

____
Patient Name (Printed)

_______________________________________ _____________________
Patient Signature Date

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