

**WYOMING SURGICAL ASSOCIATES, P.C.**  
**James A. Anderson, MD      Todd H. Beckstead, MD**  
**Lane L. Smothers, MD      Robert C. Ratcliff, MD**

**MEDICATIONS CURRENTLY TAKING - 2008**

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**ARE YOU CURRENTLY TAKING ANY BLOOD THINNERS?       YES       NO**

**ARE YOU DIABETIC?       YES       NO      Height: \_\_\_\_\_      Weight: \_\_\_\_\_**

**PLEASE LIST ALL ALLERGIES: \_\_\_\_\_**

\_\_\_\_\_

Name of Medication	Dose (mg)	How often do you take?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient's Signature: \_\_\_\_\_

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**PATIENT INFORMATION - 2008**

Date: \_\_\_\_\_ Referred by: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth date: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Marital Status:     Single             Married             Divorced             Widowed

Employer: \_\_\_\_\_ Employer Phone Number: \_\_\_\_\_

**If retired, please put retired/date of retirement. If student, please put name of school/part or full time**

**SPOUSE INFORMATION**

Spouse Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth date: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Employer: \_\_\_\_\_

**(If retired, please put retired/date of retirement)**

Employer Phone Number: \_\_\_\_\_

**RESPONSIBLE PARTY (IF OTHER THAN PATIENT PLEASE FILL IN BELOW)**

Name & Relationship: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Birth Date: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**EMERGENCY INFORMATION**

Name of friend or relative: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

DOCTORS YOU HAVE SEEN IN CASPER: 1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**Please note that we now require a copy of your Medicare, Medicaid and or Insurance Card to verify the mailing address, phone number and the spelling of your name as shown on each individual card. We can not file insurance claims for you without the birthdate and social security number of the policy holder.**

**We are also requiring a copy of your driver's license or other picture id that includes your signature. This is to be able to verify your identity in the event of requests for release of Private Health Care information.**

**We appreciate your help and understanding of these requests.**

**PRIMARY INSURANCE INFORMATION**

Primary Insurance Carrier: \_\_\_\_\_

Insurance Policy Number: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_  
\_\_\_\_\_

Name of Insurance **Policy Holder**: \_\_\_\_\_

Relationship of **Policy Holder** to you: \_\_\_\_\_

**Policy Holder's** Birth date: \_\_\_\_\_ **Policy Holder's** Social Security Number: \_\_\_\_\_

**SUPPLEMENTAL INSURANCE INFORMATION**

Supplemental Insurance Carrier: \_\_\_\_\_

Supplemental Insurance Policy Number: \_\_\_\_\_

Supplemental Insurance Company Address: \_\_\_\_\_  
\_\_\_\_\_

Name of Supplemental Insurance **Policy Holder**: \_\_\_\_\_

Relationship of Supplemental **Policy Holder** to you: \_\_\_\_\_

Supplemental **Policy Holder's** Birth date: \_\_\_\_\_

Supplemental **Policy Holder's** Social Security Number: \_\_\_\_\_

## **AUTHORIZATION AND FINANCIAL UNDERSTANDING**

- By accepting the medical services provided to me by James A. Anderson, MD, Todd H. Beckstead, MD, Lane L. Smothers, MD and/or Robert C. Ratcliff, MD or any other employee of the corporation, I agree to be financially responsible for the charges billed by Wyoming Surgical Associates, P.C. for those services.
- If there is medical insurance which will cover all or a portion of the charges I incur by James A. Anderson, MD, Todd H. Beckstead, MD, Lane L. Smothers, MD and/or Robert C. Ratcliff, MD or any other employee of the corporation for my treatment, I hereby assign those insurance benefits to Wyoming Surgical Associates, P.C., and authorize the insurance benefits to be paid directly to Wyoming Surgical Associates, PC. This assignment will remain in effect until revoked by me in writing.
- I understand that if my insurance benefits do not cover all of the charges for my treatment, including what my insurance company classifies as over reasonable and customary charges, that I am responsible to pay any outstanding balances, and that if Wyoming Surgical Associates, P.C. is required to turn my account over to an attorney or collection agency for collection, that I will be responsible for all reasonable attorney's fees and costs of collection.
- I understand that it may be necessary for Wyoming Surgical Associates, P.C. to disclose medical information about my treatment to my insurance companies, employer, or third-party payers in order to process a claim on my behalf.
- A photocopy of this assignment and financial agreement is to be considered as valid as the original.
- **I understand that it is my responsibility to contact my insurance company for pre-authorization on procedures.**

I hereby give my permission for any employee of Wyoming Surgical Associates, PC as well as any physician's office or facility to which I may be referred to contact me at:

1. My work phone
2. My work phone and leave a message to call back
3. My home phone and leave a message to call back
4. My home phone and leave a detailed message on either an answering machine or with whoever answers the phone.
5. Any other verbal or written contact I have provided to your office for both call back and detailed messages.

Please cross out any of the above that you do not want us to do.

**Patient's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_