

Benjamin J. Hung, M.D.
Ray Taddeucci, M.D.



575 South 70th Street, Suite 310 Lincoln, NE 68510
402-441-4760

**PLEASE NOTE, THIS INFORMATION IS NECESSARY TO PROVIDE THE SUPERIOR CARE YOU DESERVE
PLEASE COMPLETE IN ITS ENTIRETY**

PATIENT INFORMATION: Family Doctor: _____ Referring Doctor: _____

LEGAL NAME: _____

SEX: Male Female DATE OF BIRTH: _____ AGE: _____ SOC. SEC.# _____

EMAIL _____ MARITAL STATUS: Married Single Widowed Divorced

HOME ADDRESS: _____

STREET _____ P.O. BOX _____

CITY _____ STATE _____ ZIP CODE _____ HOME PHONE: (____) _____

CELL PHONE: (____) _____

May we leave messages at your home and/or your place of employment? Yes No Signature _____

EMPLOYER/WORK: WORK RELATED INJURY: Y N DATE OF ACCIDENT: ____/____/____

CIRCLE ONE: EMPLOYED UNEMPLOYED DISABLED RETIRED STUDENT

PATIENT'S EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

STREET _____ CITY _____ STATE _____ ZIP CODE _____

WORK PHONE: (____) _____

EMERGENCY CONTACT: Do you consent to release of information to this contact? Yes No

NAME _____ RELATION _____

(LAST, FIRST, M. I.)

HOME ADDRESS: _____

STREET _____ CITY _____ STATE _____ ZIP CODE _____

HOME PHONE: (____) _____ BUSINESS PHONE: (____) _____

PLEASE LIST AN ALTERNATE NUMBER (CELL PHONE,PAGER, ETC.) (____) _____

INSURANCE INFORMATION:

NO INSURANCE: _____

DO YOU HAVE MEDICARE? _____ MEDICARE #: _____

DO YOU HAVE MEDICAID? _____ MEDICAID #: _____

INSURANCE THROUGH: EMPLOYER ____ SPOUSE ____ INSURED'S EMPLOYER _____

INSURANCE COMPANY NAME: _____

NAME OF POLICY HOLDER: _____ BIRTH DATE: _____ SOC. SEC. #: _____

INSURANCE COMPANY ADDRESS: _____

STREET _____ CITY _____ STATE _____ ZIP _____

POLICY ID #: _____ GROUP #: _____

If you have additional policies, please provide this information on a separate sheet. (over)

AUTHORIZATION FOR TREATMENT

Patient Signature _____ **Date** _____

If patient is an emancipated adult, patient can sign for self.
If patient is under the age of 19, incapacitated, or ward of the state must have signature below.

**Guardian/
Parent Signature** _____ **Date** _____

ASSIGNMENT OF BENEFITS

Commercial Insurance Companies Only

I request payment of all medical claims be made directly to Surgical Associates, P.C. on behalf of myself or my dependent. I understand that I will be financially responsible for any balances not covered under the guidelines of my insurance company contract.

SIGNATURE _____ ***DATE*** _____

MEDICARE PATIENTS ONLY

ONE TIME AUTHORIZATION

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Surgical Associates, P.C. for any services furnished to be by any physician associated with the group. I authorize any holder of medical information about me to release to the Centers for Medicare And Medicaid Services (CMS) and its agents any information needed to determine these benefits for the benefits payable for related services.

If applicable, I also authorize payment of Medigap benefits to Surgical Associates, P.C. for all claims filed on my behalf.

BENEFICIARY NAME _____ MEDICARE# _____
(HIC)

**BENEFICIARY/
GUARDIAN SIGNATURE** _____ **DATE** _____