Advanced Southern Surgical Associates, LLC
Johnny Perez, M.D.
604 N. Acadia Road, Suite 406
Thibodaux, LA 70301
(985) 446-2524

PATIENT INFORMATION

NAME:_____
PHONE NUMBER:_____

ADDRESS:_____

CITY:_____**STATE:**_____
ZIP CODE:_____

SOCIAL SECURITY #:_____ **DATE OF BIRTH:**_____
AGE:_____

SEX:_____**MALE** _____**FEMALE SINGLE**_____ **MARRIED**_____ **WIDOWED**_____
DIVORCED_____

PATIENT EMPLOYED BY:_____
WORK NUMBER:_____

IN CASE OF EMERGENCY WHO SHOULD BE NOTIFIED?_____

REFERRED BY:_____

INSURANCE

INSURANCE COMPANY:_____

POLICY #:_____ **GROUP #:**_____
INSURANCE ADDRESS:_____

PERSON RESPONSIBLE FOR ACCOUNT:_____

RELATION TO PATIENT:_____**BIRTHDATE:**_____
SS #:_____
ADDITIONAL INSURANCE COMPANY:_____

POLICY #:_____
GROUP #:_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Bariatric & Advanced Surgical Specialists, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I give my consent to Bariatric & Advanced Surgical Specialists, LLC to release any and all medical information to any doctor and/or hospital that I may be referred to by Bariatric & Advanced Surgical Specialists, LLC.

SIGNATURE ON FILE:_____
DATE:_____
(PATIENT OR LEGAL GUARDIAN)