Advanced Southern Surgical Associates, LLC
Johnny Perez, M.D.
604 N. Acadia Road, Suite 406
Thibodaux, LA 70301
(985) 446-2524 (985) 447-2329

PATIENT INFORMATION

NAME:_____ PHONE #:_____

ADDRESS:_____ CELL #:_____

CITY:_____ STATE:_____ ZIP CODE:_____

EMAIL ADDRESS: _____

SOCIAL SECURITY #:_____ DOB:_____

SEX: M F RACE: _____ **Marital Status: S M D W**

PATIENT EMPLOYED BY:_____ WORK NUMBER:_____

IN CASE OF EMERGENCY _____

PHONE # _____ RELATIONSHIP: _____

REFERRED BY: _____

PRIMARY CARE PHYSICIAN (Family Dr.): _____

INSURANCE COMPANY:_____

POLICY #:_____ GROUP #:_____

PERSON RESPONSIBLE FOR ACCOUNT:_____

RELATION TO PATIENT:_____ DOB:_____ SS #:_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to either of the above named medical practices 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 release any and all medical information to any doctor and/or hospital of which I may be referred.

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