TRI-CITY COLO-RECTAL SURGERY, LTD.
K.S. Venkatesh, M.D., F.R.C.S. (c) ♦ David M. Larson, M.D., F.A.S.C.R.S.
Robert A. Campbell, M.D., F.A.C.S. ♦ Krishna A. Venkatesh, M.D., F.A.C.S. ♦ Hekmat Hakiman, M.D., F.A.C.S.
2223 East Baseline Road, Suite A
Gilbert, Arizona 85234
Phone (480) 835-5302 ♦ Fax (480) 844-2081

Date: _____ Referred by: _____ Primary Care Doctor: _____

Patient Name: _____ SS#: _____ / _____ / _____
First Initial Last

DOB: _____ / _____ / _____ Age: _____ ○Male /○Female Race: _____ Ethnicity: _____
(circle one)

Primary Language: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____ Work Phone: (_____) _____ /_____
ext

Your Employer: _____ Address: _____

PHARMACY NAME: _____ **PHARM PHONE**: (_____) _____ **PHARM ZIP**: _____

Spouse Name: _____ DOB: _____ / _____ / _____
First Initial Last

Spouse Employer: _____ Address: _____

Spouse SS#: _____ / _____ / _____ Work Phone: (_____) _____ /_____ Alternate: (_____) _____
ext

EMERGENCY CONTACT: _____ **DOB:** ____ / ____ / ____ **RELATIONSHIP**: _____

PHONE: (_____) _____ **ALTERNATE PHONE**: (_____) _____

If Patient is a Minor:

Parent Name: _____ DOB: _____ / _____ / _____
First Initial Last

Address: _____ City: _____ State: _____ Zip: _____

Parent Employer: _____ Address: _____

Parent SS#: _____ / _____ / _____ Home Phone: (_____) _____ Work Phone: (_____) _____

INSURANCE INFORMATION

Primary: _____

Address: _____

_____

Phone: (_____) _____

ID#: _____ Group #: _____

Insured Name: _____

Secondary: _____

Address: _____

_____

Phone: (_____) _____

ID#: _____ Group #: _____

Insured Name: _____

NOTE: If your insurance requires a referral or authorization for office visits, it is <u>your responsibility</u> to obtain this prior to your visit.
I authorize the release of medical information necessary to process insurance claims. I authorize payment of the medical benefits to Tri-City Colo-Rectal Surgery, Ltd. for the services rendered. I understand that I am responsible for any charges or balance not covered by my insurance carrier.

Patient Signature: _____ Date: _____
Lifetime Signature

Parent or Guardian Signature: _____ Date: _____
Lifetime Signature