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**PIONEER VALLEY SURGICAL ASSOCIATES, P.C.**

2 Medical Center Drive, Suite 404 ♦ Springfield, MA 01107 ♦ TEL: (413) 736-3163

**(PLEASE PRINT)**

<b>DATE:</b>		<b>REFERRED TO PVSA BY:</b>		<b>PRIMARY CARE PHYSICIAN:</b>	
<b>DO YOU HAVE ANY LATEX ALLERGIES?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO					
<b>PATIENT INFORMATION</b>					
<b>DATE OF BIRTH:</b>		<b>AGE:</b>	<b>SEX:</b> <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<b>SOCIAL SECURITY #:</b>
<b>PREFIX</b>	<b>PATIENT'S NAME:</b>			<b>MARITAL STATUS</b>	
<input type="checkbox"/> MR <input type="checkbox"/> MRS <input type="checkbox"/> MS <input type="checkbox"/> MISS	LAST	FIRST	MIDDLE	<input type="checkbox"/> SINGLE <input type="checkbox"/> MAR <input type="checkbox"/> DIV <input type="checkbox"/> SEP <input type="checkbox"/> WID	
<b>MAIDEN NAME:</b>		<b>IS THIS YOUR LEGAL NAME:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		<b>IF NOT, WHAT IS YOUR LEGAL NAME:</b>	
<b>HOME ADDRESS:</b>			<b>MAILING ADDRESS (IF DIFFERENT):</b>		
<b>HOME PHONE:</b>		<b>CELLULAR PHONE:</b>		<b>WORK PHONE:</b>	
<b>EMPLOYMENT</b>					
<b>OCCUPATION:</b>		<b>EMPLOYER:</b>		<b>EMPLOYER ADDRESS:</b>	
<b>IN CASE OF EMERGENCY</b>					

**EMERGENCY CONTACT NAME:** \_\_\_\_\_

**RELATIONSHIP TO PATIENT:** \_\_\_\_\_

**HOME PHONE:** (        ) \_\_\_\_\_ **OTHER:** (        ) \_\_\_\_\_

**INSURANCE**

**PRIMARY INSURANCE:** \_\_\_\_\_

**INSURANCE ID #:** \_\_\_\_\_ **GROUP #:** \_\_\_\_\_

**SUBSCRIBER NAME:** \_\_\_\_\_

**SUBSCRIBER DATE OF BIRTH:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**INSURANCE (CONTINUED)**

**SECONDARY INSURANCE:** \_\_\_\_\_

INSURANCE ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_

SUBSCRIBER DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

**ADDITIONAL INSURANCE:** \_\_\_\_\_

INSURANCE ID #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_

SUBSCRIBER DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PERSON RESPONSIBLE FOR PAYMENT (OTHER THAN PATIENT) REGARDLESS OF INSURANCE**

**PERSON RESPONSIBLE FOR BILL:** \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
(IF DIFFERENT FROM ABOVE)

\_\_\_\_\_

HOME PHONE: (        ) \_\_\_\_\_ OTHER: (        ) \_\_\_\_\_

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*The above information is true to the best of my knowledge. I authorize Pioneer Valley Surgical Associates, P.C. physicians and personnel to administer, care, treat and/or perform any procedure which is considered necessary and advisable by the physicians of Pioneer Valley Surgical Associates, P.C.*

*I authorize Pioneer Valley Surgical Associates, P.C. to forward copies of my medical records to my primary and/or referring physician for the purpose of continuing treatment.*

*I authorize any physician, health care practitioner, hospital or medical care facility to provide all information on the above patient's medical history to Pioneer Valley Surgical Associates, P.C.*

*I, the undersigned, hereby authorize payment directly to Pioneer Valley Surgical Associates, P.C. of medical/surgical benefits, if any, otherwise payable to me under the terms of my health insurance policy. I fully understand that I am primarily and financially responsible for fees incurred by the above patient. I further understand that payment is not contingent on any settlement, judgment or verdict by which the above patient may eventually recover said medical/surgical fees.*

*I have read this consent form carefully, and understand its contents.*

\_\_\_\_\_  
**SIGNATURE OF PATIENT, PARENT OR GUARDIAN**

\_\_\_\_\_  
**DATE**