Miami Surgery

Miami Surgery LLC
20200 W Dixie HWY
Aventura FL 33180

Registration Information

Patient's Name: _____
Last First MI

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home #: _____ **Work #:** _____ **Cell #** _____

E-Mail Address: _____ **Driver License #:** _____

Social Security #: _____ **Date of Birth:** _____ **Age** _____

Marital Status: S M D W **Sex:** M F **Primary Language Spoken:** _____

Ethnicity: _____ **Race:** _____

Employer: _____ **Occupation:** _____

Emergency Contact: _____ **Phone:** _____

Who may we thank for your referral _____

Can we send you mailings and solicitations via e-mail? Yes___ No___

Purpose of your Visit _____

Insurance Information

Company Name: _____ **Policy #:** _____ **Group #** _____

Insured Name: _____ **Insured Date of Birth:** _____

I agree that should my insurance policy have a deductible, or not cover Dr. Lamperts' fee for service, I will be responsible for the balances due in addition to interest compounded at 1.5% per month if not paid promptly.

I agree that should this account be referred to an agency or attorney for collections, that I will be responsible for all collection costs, attorney fees and court cost, and interest fees

I certify the insurance information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____ _____
Signature (Parent if Minor) ***Date***