Douglas W. Yoder, MD, F.A.C.S J. I. Alammar, MD, F.A.C.S, F.I.C.S
Blanchard Valley Surgical Specialists, Inc.
1725 South Main Street
Findlay, OH 45840
Phone: 419/423-0424 Fax: 419/423-0641

Patient: _____
First Middle Initial Last

Address: _____ **City:** _____ **State:** _____

Zip: _____ **Home Phone:** _____ **Cell Phone:**_____

Next Of Kin/Person To Notify: _____Relation:_____

Phone: _____

Alternate Contact (Not Living w/you): _____Relation:_____

Phone: _____

Sex: Male Female **Marital Status:** Single Married Widowed Divorced Separated Life Partner

Race: ☐ Black/ African American ☐ American Indian/Alaskan ☐ Native Hispanic ☐ Asian/Pacific Islander ☐ White ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Date of Birth: _____ **Social Security No.:** _____

Employer: _____ **Address:** _____

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

Family Doctor: _____ **Referred by:** _____

Preferred Pharmacy_____

Insured Name: _____
(fill out only if patient is NOT the policy holder)

Address (if different from patient) _____

Insured Date of Birth: _____ Insured Social Security No.: _____
(must have to file) (must have to file)

Person responsible for bill, if patient is a minor: _____

I hereby authorize the release of any medical information necessary to process a claim for me and/or my dependent(s). I also authorize the payment of medical benefits directly to Blanchard Valley Surgical Specialists, Inc. for services rendered in my care and/or the care of my dependent(s), realizing I am personally responsible for the charges incurred, including items to be non-covered.

Our office reserves the right to utilize Physician Assistants in the operating room. I agree to be personally responsible for deductible, co-pay and any other unpaid balances for services rendered.

Signed: _____ **Date:** _____