Bay Surgery Center
6633 Telegraph Avenue, Suite B
Oakland, CA 94609

PATIENT INFORMATION SHEET

Today's Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: _____ Alternate Telephone: _____

Birth date: _____ Social Security Number: _____

INSURANCE (private or commercial insurance only):

Name of Insured: _____

Relationship: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Insured DOB: _____ Insured SSN: _____

Assignment of Insurance Benefits: I authorize the filing of insurance claims on my behalf for services rendered. I also authorize payments to be made directly to this facility for any benefits, both basic and major medical, otherwise payable to or on behalf of the patient for all services rendered.

_____ _____
Signature of patient, parent, legal guardian or legal representative Date