PREMIER SURGICAL ASSOCIATES
NEW PATIENT INFORMATION FORM (PLEASE PRINT)

Date_______________

PATIENT INFORMATION

Patient Name (last, first, MI)	M	F	Marital Status	Race	DOB	Age	Social Security No.

Street Address	City, State, Zip Code	E-mail Address

Home Phone	Cell Phone	Employer	Occupation

Height	Weight	BMI	Body Type			Work Phone
			S	M	L	

Do You Have a Living Will? YES / NO	Does any one have "Durable Power of Attorney for Healthcare" for you? YES /NO Name and Phone if yes:

SPOUSE OR GUARDIAN INFORMATION

Spouse or Guardian's Name	DOB	Home Phone	Employer	Social Security No.

Street Address	City, State, Zip Code	Work Phone

FAMILY \ REFFERING PHYSICIAN INFORMATION

Name of Family Doctor	Street Address	City, State, Zip Code

Office Phone Number	Office Fax Number	Name of Doctor who referred you to us	Referring Phone Number

Name of other Doctors you see	Specialty	Phone Number

EMERGENCY CONTACT INFORMATION

In case of Emergency Notify	Relationship to Patient	Home Phone	Work or Cell Phone

INSURANCE INFORMATION **(please be as complete as possible)**

Insured Name	Effective Date	Responsible (self, spouse, or other)	Plan type (HMO, PPO, POS, etc.)

Primary Insurance	Street Address	City, State, Zip Code	
Member ID	Group ID	Phone Number	Fax Number
Secondary Insurance	Street Address	City, State, Zip Code	
Member ID	Group ID	Phone Number	Fax Number

Notice of Privacy Practices for Protected Health Information

I have reviewed a copy and been given an opportunity to ask questions about and understand Premier Surgical Associates' Notice of Privacy Practices (Notice). This notice explains how my Health information is used and explains certain rights that I have regarding my Health Information. It is our policy to release Protected Health Information only to the patient and other healthcare providers unless otherwise required by the law.

Patient or Guardian Signature ___________________________________ Date: _______________________________________

Medical Records Release

I hereby authorize Premier Surgical Associates, PLLC to release any information in my medical chart to any medical practitioner, doctor, hospital, medical institution to whom I mat be referred to assist with my care. Additionally, I authorize any request for medical information from any medical practitioner, doctor, hospital, medical institution to assist in my care.

Patient or Guardian Signature ___________________________________ Date: _______________________________________