

PREMIER SURGICAL ASSOCIATES

NEW PATIENT INFORMATION FORM (PLEASE PRINT)

DATE _____

PATIENT INFORMATION

Social Security No. _____ Patient Name (First, Middle, Last) _____

Sex: M F (circle one) Date of Birth _____

Marital Status: Single, Married, Divorced, Widowed, Legally Separated (circle one)

Race: Caucasian, Black, Hispanic, Asian, Native American, Other, Choose Not to Specify (circle one)

Language: English, French, Spanish, Chinese, Japanese, Korean, Sign Language, Vietnamese, Other (circle one)

Employment Status: Employed, Unemployed, Self Employed, Disabled, Retired, Full-time Student, Part-time Student (circle one)

Employer _____

Patient Mailing Address _____ City _____ State _____ Zip _____

E-mail Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Referring Physician (Include Phone No.) _____

Other Healthcare Providers (Include Phone No.)

Primary Care _____ Cardiology _____

Pulmonary _____ Endocrinology _____

Nephrology _____ Dialysis Center _____

INSURANCE INFORMATION

Primary Insurance Company _____ Group No. _____ Member ID _____

Specialist Office Co-pay Amount _____ Subscriber's Social Security No. _____

Primary Insurance Subscriber: Patient, Other (circle one)

Subscribers Name (First, Middle, Last) _____ Sex M F (circle one)

Marital Status: Single, Married, Divorced, Widowed, Legally Separated (circle one) Subscriber's Date of Birth _____

Subscribers address (if different from patient) _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Patient Relationship to Subscriber: Self, Child, Wife, Husband, Parent, Other (circle one)

NEW PATIENT INFORMATION FORM, CONTINUED

Secondary Insurance Company _____ Group No. _____ Member ID _____

Specialist Office Co-pay Amount _____ Subscriber's Social Security No. _____

Secondary Insurance Subscriber: Patient Other (circle one)

Subscribers Name (First, Middle, Last) _____ Sex M F (circle one)

Marital Status: Single, Married, Divorced, Widowed, Legally Separated (circle one) Subscriber's Date of Birth _____

Subscribers address (if different from patient) _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Patient Relationship to Subscriber: Self, Child, Wife, Husband, Parent, Other (circle one)

WORKERS COMPENSATION or AUTO INSURANCE INFORMATION

Your Supervisor _____ Supervisors Phone No. _____

Workers Compensation or Auto Insurance Phone No. _____

Claims Address _____ City _____ State _____ Zip _____

Adjusters Name _____ Adjusters Phone No. _____

Claim No. _____ Approval No. _____

Date of Injury _____ Did injury occur at work: Y N (circle one) Auto Accident: Y N (circle one)

Briefly describe injury or accident _____

EMERGENCY CONTACT INFORMATION

Contact Name (First, Middle, Last) _____ Sex: M F (circle one)

Language: English, French, Spanish, Chinese, Japanese, Korean, Sign Language, Vietnamese, Other (circle one)

Home Phone _____ Cell Phone _____ Work Phone _____

Is Contact parent or guardian: Y N (circle one)

Patient Relationship to Contact: Child, Wife, Husband, Parent, Grandparent, Other (circle one)

Contact is a Parent/Guardian: Y N (circle one)

NEW PATIENT INFORMATION FORM, CONTINUED

PHARMACY

Patient's Preferred Pharmacy _____

Pharmacy Address _____ City _____ State _____ Zip _____

Phone No. _____

CONSENTS

Do you have any of the following:

Living Will, Do Not Resuscitate (DNR), Power of Attorney, End of Life Decision, No Cardio-Pulmonary Resuscitation (CPR), None (circle any that apply)

List names of anyone you give us permission to release your medical information to, their relationship to you and phone no.

May we leave a message for you on your phone at: home, work, cell (circle all that apply)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGED

I have been given an opportunity to review, ask questions about and understand Premier Surgical Associates' Notice of Privacy Practices for Protected Health Information (Notice).

Patient or Guardian's Signature _____ Date _____

