

PATIENT INFORMATION SHEET

WELCOME TO OUR PRACTICE

Please complete this form and bring it with you to your scheduled appointment.

If you are taking any medication please bring your medications with you as well as your insurance card and arrive **30** minutes prior to your appointment.

PATIENT INFORMATION

Title _____ Last Name _____ First Name _____ Middle Initial _____

Street Address _____ Apartment Number _____

Mailing Address _____
(if different from street address)

Zip Code _____ City _____ State _____ Home Phone _____ Cell Phone _____

Social Security Number _____ Birthday _____ Sex _____ Race _____

Marital Status Single Married Divorced Widowed Separated Student Full-time Part-time

Employment Full-time Part-time Unemployed Retired Relationship to Insured Self Spouse Child Other

Employer/School Name _____

Street Address _____ Apartment Number _____

Zip Code _____ City _____ State _____ Business Phone _____

INSURED/PARENT/LEGAL GUARDIAN (IF OTHER THAN PATIENT)

Title _____ Last Name _____ First Name _____ Middle Initial _____

Street Address _____ Apartment Number _____

Mailing Address _____
(if different from street address)

Zip Code _____ City _____ State _____ Home Phone _____

Social Security Number _____ Birthday _____ Sex _____ Race _____

Marital Status Single Married Divorced Widowed Separated Student Full-time Part-time

Employment Full-time Part-time Unemployed Retired Relationship to Insured Self Spouse Child Other

Employer/School Name _____

Street Address _____ Apartment Number _____

Zip Code _____ City _____ State _____ Business Phone _____

INSURANCE INFORMATION
IF INSURANCE CARD NOT AVAILABLE

Primary Insurance Company _____

Secondary Insurance Company _____

OVER -->

**Patient Consent to the Use and Disclosure of Health Information
for Treatment, Payment, or Healthcare Operations**

I, _____ consent to treatment by the physicians of Associates In Surgery, PA.

Please enter your name on this line

I understand that no guarantee will be made to the outcome of my care or treatment. I understand I may be prescribed medication during the course of my treatment that may make operating heavy equipment or driving a vehicle dangerous. I understand I am taking full responsibility for my own actions while I am under the influence of these medications. _____

Please Initial

I understand that as part of my health care, Associates in Surgery, PA originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity to include my insurance company. I understand I am personally responsible for all co-payment, co-insurance and deductibles due. I understand that if my account is delinquent all payments received may be applied to any past due amount I may owe Associates In Surgery, PA. Should collections actions be required to collect the balance on my account I assume full responsibility for all cost incurred. _____

Please Initial

I consent to Associates in Surgery, PA utilizing telephone voice mail and answering machines for the purpose of leaving an appointment reminder or a message to include name and phone number to call.

I fully understand and accept / decline the terms of this consent.

Patient's Signature

Date

FOR OFFICE USE ONLY

- Consent received by _____ on _____.
- Consent refused by patient, and treatment refused as permitted.
- Consent added to the patient's medical record on _____.

PLEASE COMPLETE BOTH SIDES OF THIS FORM, SIGN, DATE AND RETURN TO THE RECEPTIONIST. THEN FULLY COMPLETE THE NEXT PAGE WHICH IS YOUR MEDICAL HISTORY FORM.