PATIENT INFORMATION

Patient Name: SS#

Address: City: State: Zip:

Driver License #: State: Gender: ☐ Male ☐ Female

Date of Birth: Age: Marital Status: Home Phone: ( )

Allergies/Drug Hypersensitivities: Cell Phone: ( )

Employer: Business Phone: ( )

Business Address City: State: Zip:

Name of Spouse/Parent: SS#

Spouse/Parent Address: City: State: Zip:

Spouse/Parent Home Phone: ( ) *(if patient is minor)* Parent Driver License# State

Spouse/Parent Employer: Business Phone: ( )

EMERGENCY CONTACT

Contact Telephone #: ( ) Name Relationship:

We will be contacting you after your procedure to check on your recovery. Where can we reach you the evening of or day after your procedure? (_____) _____--_____

INSURANCE/PAYMENT INFORMATION:

Type of Payment: ☐ Insurance *(attach photocopy of information)* ☐ Cash ☐ Lien *(attach Lien document)*

Primary Insurance _____ Policy #:_____ Policy Holder: _____

Secondary Insurance Policy #: Policy Holder:

Patient/Responsible Adult Signature: Date:

Patient/Responsible Adult Print Name: *Relationship to Patient

**If signed by person other than patient*

Interpreter (If required) Signature: Print Name

Interpreter relationship to patient (if applicable)

Fill out this section ONLY if you accept financial responsibility for the patient for whom you have NO legal responsibility.

I, the undersigned person, hereby certify that I have accepted total financial responsibility for the above patient, for the care/treatments rendered to the patient by the Center and all their providers including but not limited to: surgeons, anesthesiologists, radiology, laboratories, and clinical care workers. I understand that I do not currently have any legal responsibility to provide financial support for this patient. I also understand that, by signing below, I agree to personally accept full responsibility for all financial costs associated with the care/treatments/services provided to the patient by Center. Furthermore, I certify that I have had the opportunity to ask all questions related to this matter and was given adequate answers. Please fill in all sections below and sign where indicated.

Last Name: First M.I. SS#:

Relationship to Patient: Home phone: Date of Birth:

Address: City State Zip

Driver License OR other photo ID: # Type of ID: State issued:

Occupation: Employer: Bus Phone:

Signature of Responsible Party Print Name:

SOUTH COAST SPECIALTY SURGERY CENTER