

PATIENT INFORMATION

PLEASE PRINT

Patient's Name: _____ Marital Status (M/S/D): _____

Address: _____
Street City State Zip

Mailing Address: If different than above _____

Birthdate: ___/___/___ Social Security#: ___/___/___ D.L.# _____ City State Zip
Home Phone: () - -

Message Phone: () - Cell Phone: () - Work Phone: () - Other Phone: () -

Patient's Employer: _____ Occupation: _____

Employer's Address: _____
Street City State Zip

ADDITIONAL INFORMATION

PLEASE PRINT

Spouse/Parent/Guardian Name: _____ Phone: () -

Spouse/Parent/Guardian Birthdate: ___/___/___ Social Security#: ___/___/___ D.L.# _____

Spouse/Parent/Guardian Employer: _____ Work Phone: () -

Spouse/Parent/Guardian Employer Address: _____
Street City State Zip

Name of nearest relative (NOT LIVING WITH YOU) _____

Name	Relationship
Street Address City State Zip	() - Phone

Date of Injury: _____ Work Related? YES / NO If Yes describe how? _____

Please describe your main complaint. _____

How were you referred to us? _____

Has any member of your family been a patient at Indio Surgery Center in the past? Yes No _____
(if yes, patient's name)

PRIMARY INSURED INFORMATION

PLEASE PRINT

Insured Name: _____ Relation to Patient: _____

Primary Insurance Carrier: _____

Name	Street Address	City	State	Zip
I.D # _____ Group#: _____	Policy# _____	Phone# () -		

SECONDARY INSURED INFORMATION

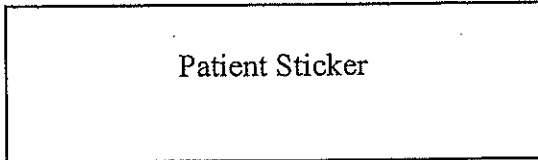
If you have a secondary insurance, please show your insurance card to the Receptionist.

All the information I have given is correct to the best of my knowledge. Even though I have insurance coverage, I know I am responsible for all charges.

SIGNATURE: _____ DATE: _____

INDIO SURGERY CENTER

PATIENT INFORMATION



Patient Sticker

We use this one