PATIENT INFORMATION

PLEASE PRINT

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

Address: _____
Street City State Zip

Mailing Address: If different than above _____
Street City State Zip

Birthdate: ___/___/___ Social Security#: ___/___/___ D.L.# _____ 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

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PATIENT INFORMATION

ISC 006 / rvsd 01/07

We use this one.

Patient Sticker