PATIENT INFORMATION

PLEASE PRINT

Patient's Name:_____ **Sex:** ☐**Female** ☐**Male**

Address: _____
Street City State Zip

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

Birth date: _____/_____/_____**Social Security#** :_____/_____/_____**D.L.#**_____ **Home Phone**: (____) _____ - _____

Message: (____) ____ - _____ **Cell Phone**: (____) _____ - _____ **Work Phone**: (_____)_____-_____ **Other Phone**: (____) _____ - _____

Race: ☐**Hispanic** ☐**White** ☐**Asian** ☐**Native Indian** ☐**Other** **Language:** ☐**Spanish** ☐**English** ☐**Other**

ADDITIONAL INFORMATION

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

Spouse/Parent/Guardian Birth date:_____/_____/_____**Social Security#**: _____/_____/_____ **D.L#**_____

Spouse/Parent/Guardian Employer:_____
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 compliant: _____

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

Insured Name: _____ **Relation to the 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