Patient Information

Name: ______________________________ Date of Birth: ___________ SSN: _______________

Address: ______________________ City: ______________ State: _______ Zip: ________

Home #: _______________ Cell #: _______________ Work #: ____________________

Which numbers may we use? ☐ Home ☐ Cell ☐ Work May we leave a message? ☐ Yes ☐ No

E-mail Address: _______________

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

☐ Employed ☐ Retired ☐ Disabled Occupation: _____________ Employer: ______________

Primary Insurance:

Policy Holder: _____________ DOB: _________ Relationship to patient: Self Spouse Dependent

Insurance Company: ___________ ID #: _______________ Group #: _____________

Secondary Insurance:

Policy Holder: _____________ DOB: _________ Relationship to patient: Self Spouse Dependent

Insurance Company: ___________ ID #: _______________ Group #: _____________

Family/Primary Physician: ____________________ Phone #: ___________________

Referring Physician: ________________________ Phone #: ___________________

Pharmacy: ______________________________ Phone #: ___________________

In regards to my protected health information, I authorize Select Surgical to discuss my medical condition/ and or release medical information to the following people:

Name: _________________ Relationship: ___________ Phone: ________________

Name: _________________ Relationship: ___________ Phone: ________________

Name: _________________ Relationship: ___________ Phone: ________________

Name: _________________ Relationship: ___________ Phone: ________________

Notice of Privacy Practices

_____ I have received a copy of Select Surgical, PLLC's HIPAA Privacy Practices

_____ I have been offered a copy of Select Surgical, PLLC's HIPAA Privacy Practices but declined a Copy.

Patient Signature: ___________________________ Date: ____________________