Premier Surgical Specialists, PC

Rev. 4/7/15

PATIENT INFORMATION

Date: _____

Reason for Visit: _____

Is This A Work Related Problem: [ ] YES [ ] NO

If "yes", have you filed a work comp claim with your employer? [ ] YES [ ] NO

Last Name: _____ First Name: _____ M.I. _____

Address: _____

City: _____ State: _____ Zip Code: _____

Birth Date: _____ Age: _____ Sex: _____ Social Security #: _____

Primary Phone (between 8:00 a.m. - 4:00 p.m.) ( )_____ Home Phone: ( )_____

Work Phone: ( )_____ Cell Phone: ( )_____

Email address: _____

I give authorization for my email address to be used for sending health information via the patient portal

Marital Status (please circle one): Married Single Divorced Widowed

Race: _____ Primary Language _____ Hispanic: Yes No

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone: ( ) _____

Referring Physician: _____ Phone: ( ) _____

Address: _____ City: _____ State: _____ Zip: _____

Family Physician: _____ Phone: ( ) _____

Address: _____ City: _____ State: _____ Zip: _____

Patient's Relationship to Insured: [ ] Self [ ] Spouse [ ] Dependent [ ] Other _____

Insured Policy Holder's Name _____ Insured Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Insured's Home Phone ( ) _____ Work Phone: ( ) _____

Insured's Social Security #: _____ Insured's Employer: _____