



Patient Profile

Doctor you are seeing today:

Account number		SSN	
Patient Name		DOB	
Referring Dr.	Dr.	PCP Name	Dr.
Referring Phone		PCP Phone	
Address		Gender	
City/State/Zip Code		Marital Status	
Home Phone		Pharmacy Name	
Cell Phone		Pharmacy Phone	
Work Phone		E Mail Address	
Employer		Employer Address	

Preferred Language: _____

Interpreter Needed: Yes: ___ No: ___

Ethnicity: Hispanic: ___ Not Hispanic: ___

Race: Asian ___ Black or African American ___ Hispanic ___ White ___ Native Hawaiian or other Pacific Islander ___ Other ___

Are you currently living at any of the following facilities? *If YES, please choose one.*

Skilled Nursing: ___ Hospice: ___ Rehab Facility: ___ Other: ___

Do you have an Advanced Will Directive, Living Will, Living Trust, or Power of Attorney? Yes: ___ No: ___

Emergency Contact Information

Name: _____ Phone: _____ Relationship: _____

Primary Insurance Information

Name: _____ Subscriber Name: _____
 Subscriber number: _____ Subscriber DOB: _____
 Relation to Patient: _____
 Subscriber Employer: _____ Subscriber SSN: _____

Secondary Insurance Information

Name: _____ Subscriber Name: _____
 Subscriber Number: _____ Subscriber DOB: _____
 Relationship to patient: _____
 Subscriber Employer: _____ Subscriber SSN: _____

The Surgical Clinic, PLLC will file your insurance or collect self pay accounts. You, the patient will be responsible for any personal balances. Any account turned to an outside collection agency will accrue additional fees on the unpaid balance including any attorney/court cost in collecting that balance.

Patient Signature

Date