

**Patient Profile**

**DOS: Doctor you are seeing today:**

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

**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:

Relationship 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. |

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*Patient Signature Date*