ABILENE SURGERY CENTER, LLC

PATIENT INFORMATION FORM

Please Print and Provide Complete Information for Each Item

First Name:_____MI:_____ **Last Name**:_____Today's Date_____

Mailing Address:_____City:_____County:_____State:_____Zip:_____

Primary Telephone:_____Cell:_____Date of Birth:_____Age:_____Sex:__

Marital Status:_____ **Social Security No:**_____ **Email:**_____

Race: White Black Asian Hispanic Non-Hispanic **Ethnicity**: Caucasian Black Hispanic Other

Preferred language: **English Spanish Other:**_____

Receive appointment reminders via: EMAIL TEXT PHONE CALL (You can select up to 3)

If you have been seen here before, under what name?_____

Employed: Y N (If yes) Full Time Part Time Self Retired Military Occupation_____

Patient in Nursing Home: **Y N** Name of Facility:_____
(If YES are they Skilled Nursing) **Y N**

FAMILY PHYSICIAN:_____

Phone #_____

EMERGENCY CONTACT:

Name:_____Relationship:_____

Contact's Address:_____ **Telephone:**_____

Is this visit related to an accident or injury? ☐ Yes ☐ No Date & Type of Injury: _____
Workers Compensation Information: _____ Telephone: _____

RESPONSIBLE PARTY / PARENT / SPOUSE:

Name:_____Relationship:_____

Occupation:_____Employer:_____

Employer's Address:_____Telephone:_____

Social Security No:_____DOB:_____

PRIMARY INSURANCE INFORMATION: **Name of Policy Holder**_____

Insurance Company:_____Date of Birth:_____SS#_____

Group Number:_____Policy Number:_____

Policyholder's Employer and Address:_____

SUPPLEMENTAL INSURANCE INFORMATION: **Name of Policy Holder**:_____

_____

Insurance Company:_____Date of Birth:_____SS#_____

Group Number:_____Policy Number:_____

Relationship to Patient: Self _____Spouse_____Child _____

We will need a copy of your insurance cards and driver's license.

Please read and sign below

I hereby authorize the physicians and staff of Abilene Surgery Center, LLC to perform procedure as necessary to assess and diagnose my condition properly, and such treatments as may be prescribed by my attending physician during any all visits to ASC, LLC. I understand that I am financially responsible for ALL charges arising from services rendered to me by ASC, LLC.

Signature: X_____ **Date:**_____

Revised: February 6, 2012; March 5, 2012;October 22,2014, May 1, 2015, August 13, 2015, Feb 23,2022