Council Bluffs Surgical Associates, P.C.

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Patient Information

Patient Name: _____ Marital Status: M S D W
Last First MI Maiden Circle One

Address: _____
Street Apt # City State Zip Code

Employer: _____ E-Mail: _____

Soc Sec #: _____ Date of Birth: _____ Age:_____ Sex: M F
Circle One

Phone: Home: _____ Work: _____ Cellular: _____

Peferred Language: _____

Race/Ethnicity: ❑ Asian ❑ Black or African American ❑ Caucasian/White ❑ Hispanic or Latino ❑ Other _____

Primary/Family Physician: _____ Referring Physician: _____

Spouse Information

Spouse Full Name: _____ Date of Birth: _____

Spouse Employer: _____ Work Phone: _____

Soc Sec #: _____ E-Mail: _____ Cellular: _____

Parent or Guardian Information If Under 18 Years of Age

Father's Name: _____ Date of Birth: _____

Address: _____ Home Phone:_____
Street Apt # City State Zip Code

Employer: _____ Work Phone:_____

Soc Sec #: _____ E-Mail: _____ Cellular: _____

Mother's Name: _____ Date of Birth: _____

Address: _____ Home Phone:_____
Street Apt # City State Zip Code

Employer: _____ Work Phone:_____

Soc Sec #: _____ E-Mail: _____ Cellular: _____

HIPAA Release of Information

Please complete the names & phone numbers where we can contact you or leave a message.
(Exception: X-Ray, Path and/or Lab results will be given only to the patient or the designated person(s).

Please contact me as follows: (check at least one)

❑ Home/Cell Telephone: (_____) _____
- ❑ Leave message with appointment date & time ❑ Leave message with call back number only ❑ Do not leave message

❑ Work Telephone: (_____) _____
- ❑ Leave message with appointment date & time ❑ Leave message with call back number only ❑ Do not leave message

❑ Written Communication: (_____) _____
- ❑ Mail to my home address: _____
- ❑ Mail to my work address: _____

If we are unable to reach you, who, if anyone/or what designated person(s), may we disclose medical and or billing information?

❑ Spouse: _____ ❑ Fiancé: _____
❑ Parent(s): _____ ❑ Adult Child: _____
❑ Adult Children: _____ ❑ Sibling(s): _____
❑ Sibling(s): _____ ❑ Other (Relative/Friend): _____
❑ Other (Relative/Friend): _____ ❑ Other (Relative/Friend): _____

Emergency Contact Information

Name: _____ Relationship:_____

Address: _____ Phone:_____

Office Visit Information:

Reason for Visit: _____

Date of Symptoms: _____

Seen in ER: ❑ Yes ❑ No Where? _____ When?_____

If this is an injury, is the injury related to an on-the-job accident? ■ Yes ■ No (Check One)

If Yes: a) Have you reported the accident to your employer? ❑ Yes ❑ No

b) Were you referred by a Work Comp doctor? ❑ Yes ❑ No

If No: a) Was this a car accident? ❑ Yes ❑ No

b) Did the injury occur on another person's property? ❑ Yes ❑ No

Workmen's Compensation Information:

Company Name: _____ Phone #: _____

Address: _____
Street Apt # City State Zip Code

Supervisor Name: _____ Date of Injury: _____

Have you missed any work due to the injury? _____ What symptoms: _____

What were you doing at the time of injury? _____

Do you have an attorney representing you in the above injury? ❑ Yes ❑ No

If Yes: Attorney Name: _____ Phone #: _____

Address: _____
Street City State Zip Code

Motor Vehicle Accident Information:

Date of Accident: _____

Do you have an attorney representing you in the above injury? ❑ Yes ❑ No

If Yes: Attorney Name: _____ Phone #: _____

Address: _____
Street City State Zip Code

Insurance Information: (copy of insurance card is needed)

Insurance Name: _____ Policy Holder_____
Primary Name Date of Birth

Insurance Name: _____ Policy Holder_____
Primary Name Date of Birth

If patient is a minor, please print name of parent or guardian responsible for bill: _____

Address: _____
Street City State Zip Code

Pharmacy Information:

Pharmacy Preferred: (Name) _____

_____

Pharmacy Location: _____ Phone #: _____

Notice of Council Bluffs Surgical Associates, P.C. Practices

Notice of Payment Policy

I acknowledge the receipt of the Payment Policy effective 07/01/09 from Council Bluffs Surgical Associates, P.C.

Notice of Privacy Practices

I acknowledge receipt of the Notice of Privacy Practices effective February 1, 2005 from Council Bluffs Surgical Associates, P.C.

Authorization for Consent to Treatment

I, the undersigned, give permission to treat and assign to Council Bluffs Surgical Associates, P.C., all medical benefits, if any, otherwise payable to me for services rendered. I also understand that I am financially responsible for all charges not paid by my health benefits provider. I hereby authorize the doctor to release all information necessary to secure the payment and authorize the use of this signature (or copy thereof) to provide necessary medical information to my insurance carrier upon their request.

I, knowing that I have a condition requiring diagnosis, treatment, or related medical care do hereby consent to such care, medical examination(s), operation(s), procedure(s), therapy sessions, photographs, and/or treatment by my attending physician(s), their assistant(s) or designee(s) as may be necessary in their professional judgement. I further acknowledge that no guarantees have been made to me as to the results of such care, medical examination(s), operation(s), procedure(s), therapy sessions and/or treatment.

Patients, Parent/Legal Guardian
or Power of Attorney Signature: _____ Date:_____