

## 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: \_\_\_\_\_

Preferred 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

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

## Patient Allergy Information

Medication Allergies: \_\_\_\_\_

Any food, metal, latex, adhesive allergies: \_\_\_\_\_

**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: \_\_\_\_\_