SURGERY CENTER

1101 South College Road, Suite 100
Lafayette, LA 70503
(337) 233-8603 – Tel
(337) 234-0341 - Fax

PATIENT INFORMATION

(Please Print)

Patient's Last Name ______________________________ First Name ______________________________ MI _____

Please Circle: Male Female Please Circle: Married Single Widowed Divorced Separated

Patient lives with: Mother Father Parents Other ______________________________

Mailing Address ______________________________ City ____________ State ____ Zip ________

Patients Social Security # ______________________ Date of Birth ______________________

Pts Home Ph ______________ Pts Work Ph ______________ Ext ______ Pts Cell ______________

Patient's Employer: ______________________________

ALLERGIES TO MEDICATION ______________________________

If Married, Spouse's Name ______________________ DOB ____________ Spouses Cell # ______________

Spouses Employer ______________________________ Work # ______________ Ext ________

Spouse's Social Security # ______________________________

Emergency Contact Person(s) to make medical and/or financial decisions on your behalf:

Name ______________________________ Ph ______________ Relationship ____________

Nearest Relative Not Living with You:

Name ______________________________ Ph ______________ Relationship ____________

If Patient Is 21 Years Old or Younger, Please Include the Following:

Mothers Name ______________________________ Date of Birth ______________________

Mailing Address ______________________________ City ______________ State ___ Zip __________

Home Phone ______________________ Cell Phone ______________ Social Security # ______________

Employer ______________________________ Work Phone ______________ Ext ________

Fathers Name ______________________________ Date of Birth ______________________

Mailing Address ______________________________ City ______________ State ___ Zip __________

Home Phone ______________________ Cell Phone ______________ Social Security # ______________

Employer ______________________________ Work Phone ______________ Ext ________

PERSON RESPONSIBLE FOR BILL:

Name ____ Circle: Male/Female Married/Single

Mailing Address ____City _________________________ St ____ Zip _________

Social Security # _________________________ Date of Birth _________________________

Home Ph ___________________ Work Ph _____________________ Ext __________ Cell Ph #_______________________

Employer Name: ____

What Is the Relationship to Patient: Mother Father Spouse Self Other____

INSURANCE INFORMATION:

Primary Insurance Insurance Benefit/Verification Phone # _______________________________________

Name of Insurance: ____ Insured ID# _________________________

Claims address ____City___________________________ St______ Zip ________

Is this a GROUP or INDIVIDUAL policy: Individual Group (Group # ____________________Group Name_________________)

Is this insurance through your employer: Yes No

Name of Employer: ____ Phone _____________________

Name of Person Insured (Policy Holder) ____

Social Security Number of Policy Holder ____________________________________ Date of Birth________________________

What is insureds relationship to patient: Self Spouse Father Mother Other ________________________________

Secondary Insurance (If applicable) Insurance Benefit/Verification Phone # _______________________________________

Name of Insurance: ____ Insured ID# _____________________________

Claims address ____City_________________________ St______ Zip __________

Is this a GROUP or INDIVIDUAL policy: Individual Group (Group # __________________ Group Name_______________)

Is this insurance through your employer: Yes No

Name of Employer: ____ Phone _________________________

Name of Person Insured (Policy Holder) ____

Social Security Number of Insured ______________________________________ Date of Birth ________________________

What is insureds relationship to patient: Self Spouse Father Mother Other _________________________________

Tertiary Insurance (If applicable) Insurance Benefit/Verification Phone # _____________________________________

Name of Insurance: ____ Insured ID# _________________________________

Claims address ____City________________________ St______ Zip __________

Is this a GROUP or INDIVIDUAL policy: Individual Group (Group # ____________________Group Name_______________)

Is this insurance through your employer: Yes No

Name of Employer: ____ Phone ________________________

Name of Person Insured (Policy Holder)____

Social Security Number of Insured ______________________________________ Date of Birth _______________________

What is insureds relationship to patient: Self Spouse Father Mother Other _______________________________