The Surgery Center at Lone Tree, LLC

PATIENT INFORMATION FORM

GENERAL INFORMATION

1. **Last Name**: _____ **First Name**: _____ **M / F**

   Address: _____ **City, State**: _____ **Zip Code**: _____

   SSN: _____ **DOB**: _____/_____/_____

   Please indicate phone number(s) where the Surgery Center staff may leave messages pertaining to appointment times, prescription information, and/or other Private Health Information. Please list an emergency contact as well.

   Home Phone: _____ **Msg OK?** Y N **Emergency Contact:** _____

   Work Phone: _____ **Msg OK?** Y N **Relationship:** _____

   Cell Phone: _____ **Msg OK?** Y N **Contact Phone:** _____

   E-Mail: _____

2. Is this visit due to (circle one): AUTO ACCIDENT – WORK-RELATED INJURY – OTHER INJURY – NO INJURY

   Date of Injury/onset of symptoms: _____/_____/_____ (If unsure of exact date, give best guess of month and year).

INSURANCE INFORMATION

3. **Primary Insurance Company**: _____ Phone#: _____

   Claims Address: _____

   ID/Claim# _____ Grp/Policy#: _____ Insured's Name: _____

   Insured's SSN: _____ Insured's DOB: ____/____/____

4. **Other Insurance Company:** _____ Phone#: _____

   Claims Address: _____

   ID/Claim# _____ Grp/Policy#: _____ Insured's Name: _____

   Insured's SSN: _____ Insured's DOB: ____/____/____

5. **Have you retained an attorney?** YES NO (circle one) If yes, please provide name, complete address, and phone # below.

   Atty Name: _____ Phone: _____

   Address: _____

I hereby request evaluation and treatment and grant this facility the authority to treat and examine me/my dependent and to order any examination or tests necessary to facilitate my examination or treatment. I understand that the practice of medicine is not an exact science and that there are no guarantees of the results and that every individual may respond differently to a particular treatment regimen. I understand that there are certain risks associated with any examination or treatment and that those risks will be presented and explained to me during the course of my treatment. I hereby authorize this facility and/or its clinical staff to perform examinations and treatment as necessary for my care.

Patient Signature: _____ ***Date***: _____

Patient Label

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RECORD RELEASE

CONSENT TO RELEASE PATIENT INFORMATION

_____
(Initial)

I hereby authorize the release of medical information including, but not limited to, medical history and physical examination, report of physical findings, x-rays and reports, MRIs and reports, diagnosis, prognosis, independent medical examinations, second opinion examinations, reports obtained from other physicians and providers involved with my medical care, both past and present, narrative reports, medical bills and treatment records and other such documents which may be requested from this office for the purpose of payment of claims, facilitating evaluation and/or treatment, facilitating a continuum of care and treatment, and/or arising out of any claim or action related to any aspect of my medical evaluation and treatment.

I expressly authorize the exchange of records and other documents listed above with any and all health care providers to whom I am referred to during the course of my treatment and/or any health care providers who have previously provided and/or presently provide any health-related services to me whose services may or may not be related to this accident, claim, injury or symptoms including but not limited to my primary care physician, pharmacist, etc.

Signature: **X** _____ **DATE** _____

Signature of Witness: X _____ DATE _____

Revised: 01-10-08

Patient Label