AGAVE SURGICAL ASSOCIATES, P.C.

Patient Information Form

(Please complete all lines and print)

Patient information: **Date:** _____

Name: _____ Alias: _____

Last First Middle

Social Security #: ___-___-____ Date of Birth: ___-___-____ Age: ___ Gender: ☐ M ☐ F

Street Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____ County: _____

Patient's Permanent Address *(If different from above):*

_____

Race: _____ Preferred Language: _____ Ethnicity: _____

Birth State: _____ Country of Origin: _____

Marital Status: ☐ Married ☐ Single ☐ Widow ☐ Divorced

Spouse Name: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____ Email: _____

Primary Care Physician: _____ **Referred By:** _____

Employer Information:

Employment Status: ☐ Employed ☐ Student ☐ Not Employed ☐ Retired ☐ Self Employed ☐ Military

(Please mark one)

Employer Name: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Phone #: ( ) _____ Occupation: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Legal Guardian: ☐ Y ☐ N

Address: _____ City: _____ State: _____

Phone #: ( ) _____

INSURANCE INFORMATION FORM

Is this visit due to an on the job injury? ☐Y ☐N *if yes*, the date of injury: ___-___-_____

Employer at the time of injury: _____ Phone #: ( ) _____

Please provide us with a copy of the claim report showing claim number and insurance carrier

Guarantor Information: *(for a minor or person/entity financially responsible, if other that the patient):*

Name: _____

Last First Middle

Relationship: _____ Phone #: ( ) _____

Street Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____ County: _____

Social Security #: ___-___-___ Date of Birth: ___-___-_____

Primary Insurance: PLEASE PRESENT INSURANCE CARD AND PHOTO I.D.

Name of Coverage Plan: _____

Name of Policyholder: _____ Relationship to Patient: _____

Insurance ID: _____ Group: _____ Through Employer? ☐Y ☐N

Social Security # of Policyholder: ___-___-___

Secondary Insurance:

Name of Coverage Plan: _____

Name of Policyholder: _____ Relationship to Patient: _____

Insurance ID: _____ Group: _____ Through Employer? ☐Y ☐N

Social Security # of Policyholder: ___-___-___

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I, the undersigned, authorize Agave Surgical Associates and its affiliates (Provider) to release my medical records to any referring or referred physician and my primary care. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I further agree to physician orders and associated diagnoses being sent via fax or electronic submissions, to other physicians, hospital, pharmacies and/or other diagnostic/treatment facilities. I authorize payment under my medical insurance program to be made directly to Agave Surgical Associates and I further authorize Agave Surgical Associates to release to my medical insurance company any confidential medical information which may be considered instrumental in payment of my medical claim.

Patient's Signature: _____ Date: _____