Agave Surgical Specialists

GENERAL, WEIGHT LOSS & MINIMALLY INVASIVE SURGERY

PATIENT INFORMATION FORM

(PLEASE COMPLETE ALL LINES AND PRINT)

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: ______________

PHYSICIANS

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: ________________ Zip: ____________

Phone #: ( ) ________________________

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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 than 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: ____________________

POS Reorder # 1718676