SHOALS OUTPATIENT SURGERY
an affiliate of SCA

For Office Use Only
Date: _____
Driver's License #: _____

PLEASE FILL OUT FORM COMPLETELY.

PATIENT INFORMATION:

Patient's First Name:	M.I.:	Last Name:	Patient's Social Security #:
Street Address:			Age: Date of Birth:
Mailing Address/P.O. Box:			Gender: Male Female
City:	State:	Zip:	Marital Status: (circle) S M D W
Employment: ☐ Retired ☐ Unemployed ☐ Disabled ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Active Military		Patient's Home Phone:	Cellular Phone:
Patient's Employer:		Date Employment Started:	Patient's Work Phone & Ext. #:

RESPONSIBLE PARTY IF CHILD:

Responsible Party or Mother's Name:			Responsible Party or Father's Name:		
Social Security #:	Date of Birth:	Relationship to Patient:	Social Security #:	Date of Birth:	Relationship to Patient:
Employer:		Work Phone & Ext.:	Employer:		Work Phone & Ext.:
Home Address if different from Patient's:			Home Address if different from Patient's:		
City, State or Zip:		Phone:	City, State or Zip:		Phone:

ACCIDENT INFORMATION

Are you having surgery due to an accident? If yes, date: _____
Was it work related? ☐ Yes ☐ No If so, this claim cannot be filed on personal insurance.
Was it auto related? ☐ Yes ☐ No If so, this claim cannot be filed on personal insurance.

PRIMARY INSURANCE: PLEASE NOTE: We MUST Have A Copy of Your Insurance Card

Insurance Company Name:	Effective Date:	Subscriber's Date of Birth:
Subscriber's Full Name:		Relationship to Patient:
Subscriber's SS#:	Subscriber's Employer:	Work Phone #:

SECONDARY INSURANCE: PLEASE NOTE: We MUST Have A Copy of Your Insurance Card

Insurance Company Name:	Effective Date:	Subscriber's Date of Birth:
Subscriber's Full Name:		Relationship to Patient:
Subscriber's SS#:	Subscriber's Employer:	Work Phone #:

EMERGENCY CONTACT: SOMEONE THAT DOES NOT LIVE WITH YOU

Name:	Phone Number:	Relationship to Patient:

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I have verified that there have not been any changes to this form. _____ Initial/Date
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