Westside Surgical Associates, LLP

PATIENT INFORMATION Date_____ Surgeon_____

Last name_____ First name_____ Middle initial_____

Address_____ City_____ State_____ Zip_____

Social security number_____ □ Male □ Female DOB_____ Age_____

Home phone_____ Cell phone_____ Work phone_____

●Marital status □ Child □ Divorced □ Married □ Separated □ Single □ Widowed

●Race □ American Indian □ Asian □ Black □ Declined □ Hispanic □ Pacific Islander □ White

●Language □ English □ Spanish □ Sign language □ Other _____

●Ethnicity □ Latino □ not Latino

Name of employer_____

Address_____ City_____ State_____ Zip_____

Emergency contact_____ Relationship_____ Phone_____

Address_____ City_____ State_____ Zip_____

MEDICAL INFORMATION

Referring provider_____ Phone_____

Primary physician_____ Phone_____

Cardiologist_____ Phone_____

OB/GYN_____ Phone_____

Pharmacy_____ Phone_____

Address_____ City_____ State_____ Zip_____

PRIMARY INSURANCE INFORMATION

Insurance name_____ ID number_____

SUBSCRIBER Last name_____ First name_____ Middle initial_____

DOB_____Home phone_____ Cell phone_____ Work phone_____

Patient relationship to subscriber_____

SECONDARY INSURANCE INFORMATION

Insurance name_____ ID number_____

SUBSCRIBER Last name_____ First name_____ Middle initial_____

DOB_____Home phone_____ Cell phone_____ Work phone_____

Patient relationship to subscriber_____

I authorize Westside Surgical Associates, LLP to use and/or disclose my protected health information for my care, payment, and the Practice's health care operations. I authorize release of information necessary to file a claim with my insurance company and assign payment of benefits to the physician indicated on the claim. I understand that I am financially responsible for any balance not covered by my insurance carrier. Failure to pay any balance due may result in my account being referred to a collection agency or attorney for recovery; I will be responsible for all collection agency fees and attorney's fees. A copy of this may be used in place of the original.

Signature_____ Date_____