Patient Label

Patient Information

Patient name: _____Date:_____

Soc. Sec. #: _____-_____-_____ Driver License#: _____

DOB: ____ / ____ / ____ Age: ____ Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widow

Home phone: _____-_____-_____ Cell: _____-_____-_____Work: _____-_____-_____

May we contact you at work? ◯ YES ◯ No

Email: _____Best form of contact: ◯ Home ◯ Cell ◯ Work ◯ E Mail ◯ US Mail

Home Address , (street, city and state): _____

Is this your permanent address: ◯ YES ◯ NO if not , please provide a local address

Address while in Miami: ◯ Same if not,(street, city and state):_____

Phone number that we can reach you at while staying in Miami: : _____-_____-_____

During which months do you typically reside in the area:_____

Occupation: _____ Employer;_____

Employer Address:_____ Phone: _____-_____-_____

Name of Spouse or Significant Other: _____ Phone: _____

In case of an emergency, please provide a local family member, neighbor or friend (including phone number)we may contact :

Name: _____ Relationship: _____ Phone: _____

Please note that under the patient privacy act (HIPPA) we are not allowed to share any information with anyone unless those individuals have been specifically designated by you in writing. If you desire for us to share information regarding your procedure and condition, you must list them below:

1.) _____

2.) _____

Note also that for the purpose of identification, you must provide a photo identification before being processed into the surgicenter. A valid driver's license or a passport will fulfilled this requirement. You agree to have either of these IDs photocopied to be held in your medical records.

_____ Date: _____

Patient signature