SURGERY CENTER OF SOUTH CENTRAL KANSAS

Welcome to our office. Please complete this form to the best of your knowledge.

GENERAL INFORMATION: Today's Date ____/____/____

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr. Marital Status: ☐ S ☐ M ☐ D ☐ W Gender: ☐ M ☐ F

Patient Name _____
First Middle Last

Social Security Number ____ - ____ - ____ Mother's Maiden Name _____

Home Address _____
Street City State Zip

How do you wish to be addressed? (e.g. – Mr. 1st Name, Nickname) _____

Date of Birth ____/____/____ Home Phone # (___) ____-_____ Cell Phone # (___) ____ - ____

Your Occupation _____ Employer _____ Work # (___) ____ - ____

Spouse's Name _____ Employer _____ Work # (___) ____ - ____

Emergency Contact _____ Relationship _____Phone # (___) ____ - ____

BILLING INFORMATION (if different from patient):

Name of Person Financially Responsible for Account _____

Relationship to Patient _____SSN _____ DOB ___/____/____

Home Phone # (____) _____ - _____ Work # (____) _____ - _____

Address _____
Street City State Zip

MISCELLANEOUS INFORMATION

Do you have an Advance Directive in effect? _____

Is today's visit due to a work related or auto accident? _____

If accident, date of injury, how and where it happened _____

_____

_____

Have you had back surgery? _____ Neck surgery? _____

Have you had a recent MRI or x-ray? _____

Where and when? _____

Family Physician _____

Referred by _____

This is to inform you that in addition to the physician's fee, there will be a facility fee for any procedure or surgery you have at the Surgery Center.

Signature **X** _____ Date _____