PATIENT INFORMATION

Name: ____ **Marital Status:** _______
First Middle Last

Mailing Address: ____
Street City/State Zip

Primary Contact Number: _________________________**Cell: Y or N** **Secondary Contact Number**______________________

Email Address: _____________________________________ **Preferred method of communication (circle): Email - Text - Voice**

Birth Date: _______________ **Age:** ____ **Sex:** ____ **SSN #:** _______________________ **Race/Ethnicity:** _________________

Referring Physician: _____________________________ **Primary Care Physician (PCP):** _______________________________

Preferred Local Pharmacy: ___________________________**City/Location**____

FINANCIALLY RESPONSIBLE PARTY (IF NOT SELF)

Name: ____ **Phone Number:** ____________________
First MI Last

Birth Date: _________________ **Sex:** _____ **SSN #:** _______________________ **Relation to Patient:** ___________________

Address: ____
Street **City/State** **Zip**

HIPAA (CHART ACCESS)

By listing persons below, you are granting permission for Falls Canyon Surgical Associates and staff to speak with the person(s) regarding your medical care in the event you are unable to contact us yourself. If you are a minor, we would like to know who your parents or legal guardians are so that we may be sure we are speaking with the appropriate family member.

Name Relation

1) ____

2) ____

EMPLOYMENT

Employment Status: Retired Employed Student Other: _________________

Employer Name: _______________________________________**Phone#**___________________**Fax#**___________________

I authorize Dr. Nealon, Dr. Pool, or Dr. Havel to fax return to work notes at my request_______________ **(initials)**

IN CASE OF EMERGENCY

Name: _________________________________ **Phone:** ______________________ **Relation to Patient:** ____________

AUTHORIZATION TO RELEASE INFORMATION * ASSIGNMENT OF INSURANCE BENEFIT

I hereby authorize Falls Canyon Surgical Associates to release to the insurance company named above any information (may included information protected by federal law i.e. drug, alcohol abuse or mental health information) acquired in the course of the examination of treatment**. I hereby agree to full responsibility for all expenses incurred by or on account of this patient and hereby assign to Falls Canyon Surgical Associates any and all insurance benefits due to me to the full extent of my financial obligation to said provider. I understand my insurance coverage is a relationship between my insurance company and myself and I agree to accept financial responsibility for payment for charges incurred. In the event of non-payment, I will bear the cost and/or court costs and reasonable legal fees should this be required.**

Signature: ____**Date:** ___________________________________

PRIVACY PRACTICES NOTIFICATION

I have had the opportunity to read the Notice of Privacy Practices. I understand that if I have any questions or concerns, or if I wish to receive additional copies of the notice at any time, I may do so by calling this office. (**If patient is a minor, parent or legal guardian must sign for them.)**

Signature: ____ **Date:** _________________________________