Document Type: Forms/Other
Subject: Intake Form – CB Surg Assoc

MSC001

METHODIST PHYSICIANS CLINIC

SURGICAL ASSOCIATES PATIENT INTAKE

Patient Name:_____ Marital Status: M S D W
Last First MI Maiden

Address:_____
Street Apt # City State Zip Code

Date of Birth:_____ Age:_____ Sex: M F E-Mail:_____

Soc Sec #:_____ Employer:_____

Phone: Home: _____ Work: _____ Cellular: _____

Preferred Language: _____

Race/Ethnicity: ❒ Asian ❒ Black or African American ❒ Caucasian/White ❒ Hispanic or Latino ❒ Other_____

Primary/Family Physician: _____ Referring Physician: _____

Spouse Information

Spouse Full Name: _____ Date of Birth:_____

SSN#_____ E-Mail: _____ Cellular:_____

Parent or Guardian Information If Under 18 Years of Age

Father's Name:_____ Date of Birth:_____

Address:_____ Phone:_____
Street Apt # City State Zip Code

Mother's Name:_____ Date of Birth:_____

Address:_____ Phone:_____
Street Apt # City State Zip Code

Emergency Contact Information

Name:_____ Relationship:_____

Address: _____ Phone:_____

Office Visit Information

Reason for Visit: _____

Date of Symptoms:_____

Seen in ER: ❒ Yes ❒ No Where?_____ When?_____

Pharmacy Information

Pharmacy Preferred: (Name) _____

_____

Pharmacy Location:_____ Phone #:_____

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Patient Label

NAME:_____DOB:_____

FIN:_____MRN:_____

PERMANENT PART OF MEDICAL RECORD

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METHODIST PHYSICIANS CLINIC

Insurance Information: (copy of insurance card is needed)

Insurance Name:_____ Policy Holder_____
Primary Name Date of Birth

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Primary Name Date of Birth

If patient is a minor, please print name of parent or guardian responsible for bill: _____

Address: _____
Street City State Zip Code

Workmen's Compensation Information **Is the injury related to an on-the-job accident? ■ Yes ■ No**

Company Name: _____ Phone:_____

Address:_____
Street Apt # City State Zip Code

Supervisor Name:_____ Date of Injury: _____

Have you missed any work due to the injury?_____ What symptoms:_____

What were you doing at time of injury? _____

Do you have an attorney representing you in the above injury? ❒ Yes ❒ No

If Yes: Attorney Name:_____ Phone #:_____

Address:_____
Street City State Zip Code

Motor Vehicle Accident Information **Is the injury related to a car accident? ■ Yes ■ No**

Date of Accident:_____

Do you have an attorney representing you in the above injury? ❒ Yes ❒ No

If Yes: Attorney Name:_____ Phone #:_____

Address:_____
Street City State Zip Code

HIPAA Release of Information

Please complete the names & phone numbers where we can contact you or leave a message.
Exception: X-Ray, Path and/or Lab results will be given only to the patient or designated person(s).

Please contact me as follows: (check at least one)

❒ Home/Cell Telephone: (____) _____ ❒ Cell phone/Text (____) _____
❒ Leave message with appointment date & time ❒ Leave message with call back number only ❒ Do not leave message

❒ Work Telephone: (____) _____
❒ Leave message with appointment date & time ❒ Leave message with call back number only ❒ Do not leave message

❒ Written Communication:
❒ Mail to my home address:_____
❒ Mail to my work address:_____

If we are unable to reach you, who, if anyone/or what designated person(s), may we disclose medical and/or billing information?

❒ Spouse:_____ ❒ Fiancé: _____
❒ Parent(s):_____ ❒ Adult Children: _____
❒ Sibling(s): _____ ❒ Other Relative/Friend_____

Patient /Patient Representative Signature: _____

Relationship to Patient: _____ **Date** _____

Patient Label

NAME:_____DOB:_____

FIN:_____MRN:_____

PERMANENT PART OF MEDICAL RECORD

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