

Patient Information Sheet

SURGICAL SPECIALISTS OF OKLAHOMA, PLLC

EXCELLENT SURGEONS. EXCELLENT CARE.

Date: _____ - _____ - _____ **Please Print**

Patient Name: _____ Sex: M F

Date of Birth: _____ - _____ - _____ Age: _____ SSN: _____

Marital Status: (Circle One) M S D W Race: _____

Patient Address: _____

City: _____ ST: _____ Zip: _____

Home Ph: (_____) Work Ph: _____ Cell/Pgr: _____

Email Address: _____

Referring Physician: _____ Phone: (_____)

*Primary Care Physician: _____ Phone: (_____)

*May we contact your primary care physician? _____ Yes _____ No

Employer: _____ Work Address: _____

City: _____ ST: _____ Zip: _____

Emergency Contact: _____ Phone: (_____)

(Nearest Relative - Not living at home)

Do you have insurance? (Check One) Yes _____ No _____ *** Please present insurance card to receptionist. ***

Name of Primary Insurance: _____ Secondary: _____

Policy Holder Name: _____ Policy Holder Name: _____

SSN: _____ SSN: _____

Date of Birth: _____ Date of Birth: _____

Policy Holder's Employer: _____ Policy Holder's Employer: _____

Work Ph: (_____) Work Ph: (_____)

Work Address: _____ Work Address: _____

City/ST/Zip: _____ City/ST/Zip: _____

Answer the following if patient is under the age of 18

Mother's Name: _____ SSN: _____

Mother's DOB: _____ - _____ - _____ Work Phone: _____

Employer: _____ Address: _____

Father's Name: _____ SSN: _____

Father's DOB: _____ - _____ - _____ Work Phone: _____

Employer: _____ Address: _____

I authorize the following person(s) to receive my protected health information (such as family members):

Name

Relationship

Authorization for services / Please read the following and sign at the bottom of this form

I hereby authorize payments directly to the Physician, staff, or facility for medical services rendered. I understand I am responsible for any portion of my bill not covered by my insurance company, whether as a co-pay, co-insurance, deductible, or a non-covered service. I understand office co-pays are due at the time services are rendered. I also understand all the above and state that the information provided herein is true and correct to the best of my knowledge.

Signature: _____ Date: _____