

TAMPA OUTPATIENT SURGICAL FACILITY
****** PLEASE PRINT CLEARLY & COMPLETE ALL INFORMATION ******

PATIENT INFORMATION:

NAME: _____ DATE: _____
Last First MI mm/dd/yyyy

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____ GENDER: M F
mm/dd/yyyy

HOME PHONE: _____ CELL PHONE: _____ MARITAL STATUS: S M D W

MAILING ADDRESS: _____
Street Address Lot/Apt # City State Zip

RACE: American Indian Asian / Pacific Black White Hispanic No response Other

EMPLOYED BY: _____ PHONE: _____

PRIMARY PHYSICIAN NAME: _____ PHONE: _____

EMERGENCY CONTACT INFORMATION:

PERSON TO CONTACT IN CASE OF EMERGENCY _____ PHONE _____ RELATIONSHIP _____

INSURANCE INFORMATION:

Please complete the information below and submit your insurance card if you want us to bill your health insurance.

Relationship to Insured: (Please Circle) SELF SPOUSE DEPENDENT OTHER

Primary Insurance Co mp. _____ Policy Holder (Insured): _____
Policy #/ Member ID# _____ Group #: _____
Secondary Insurance Comp. _____ Policy Holder (Insured): _____
Policy #/ Member ID# _____ Group #: _____

RESPONSIBLE PARTY FOR INSURANCE

MUST BE FILLED OUT IF PATIENT OR MINOR IS NOT THE POLICY HOLDER ON ACCOUNT

NAME: _____ PHONE NUMBER: _____
Last First MI

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

PLACE OF EMPLOYMENT: _____ PHONE NUMBER: _____

Is this a **Workman's Compensation** case? Yes No Date of Incident: _____
Is this an **Auto Accident** case? Yes No Date of Incident: _____
Adjuster's Name and Phone Number: _____ Phone: _____
Is this due to **Other Injury / Accident**? Yes No Date of Incident: _____

MEDICARE SIGNATURE AUTHORIZATION:

I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers or to the billing agent of this physician or supplier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand that this signature is a lifetime signature.

Signature

Date

PATIENT SIGNATURE:

The information completed on this form is true to the best of my knowledge.

Signature

Date