Surgery Clinic of Tupelo, P.A. Patient Information Form

Name: Last	First	MI

Mailing Address:			
City:	**State:**	**Zip:**	**Date of Birth**

Social Security #:	Sex:	M	F	Marital Status:	M	S	W	D

Email Address:	Home Phone:	Cell Phone:

Employed ☐ Unemployed ☐ Retired ☐
Employer: Work Phone: Disabled ☐ Student ☐

Emergency Contact:	Relationship:	Phone:

Language:	English ☐	Spanish ☐	Japanese ☐	Other ☐	Unavailable ☐
Ethnicity:	Non Hispanic ☐	Hispanic ☐	Declined ☐		Unavailable ☐
Race:	White ☐	Black/African American ☐	American Indian/Alaska Native ☐		Asian ☐
	Native Hawaiian/Other Pacific Islander ☐	Multiracial ☐	Declined ☐		Unavailable ☐

Person Accompanying Minor Patient age 18 and under	Name: Last First MI	Relation to Patient:

Mailing Address:			
City:	**State:**	**Zip:**	**Date of Birth**

Social Security #:	Home Phone:	Cell Phone:

Place of Work:	Work Phone:

INSURED'S INFORMATION:

Our goal is to file your insurance correctly; a front and back copy of your current card will help ensure this.

Primary Insurance- Insured's Name:	Insured's Date of Birth:
Primary Insured's Social Security #:	**Policy Holder ID#:**
Primary Insurance Name:	**Primary Insured's Employer:**
Secondary Insurance- Insured's Name:	**Insured's Date of Birth:**
Secondary Insured's Social Security #:	**Policy Holder ID#:**
Secondary Insurance Name:	**Secondary Insured's Employer:**

Disclosure of Personal Health Information:

Surgery Clinic of Tupelo, P.A. will not discuss your personal health information with anyone except those allowed under federal and state law without your authorization. Please list the names and relationships of those you authorize us to discuss your personal health information.

Name	Relationship	Daytime Phone
Name	**Relationship**	**Daytime Phone**
Name	**Relationship**	**Daytime Phone**

Patient or Guardian Signature:	Date: