**PATIENT INFORMATION**

(Please Use **BLACK INK ONLY**)

LEGAL FIRST NAME: LAST NAME: MIDDLE INITIAL:

PREFERRED NAME: Date of Birth: / / Sex: 🗌 Male 🗌 Female

Social Security Number: Preferred Pharmacy:

Mailing Address: City: State: Zip:

Primary Phone: Secondary Phone: Work Phone:

Employer: Employer Phone Number:

Primary Care Physician/Provider:

Marital Status: 🗌 Single 🗌 Married 🗌 Divorced 🗌 Widowed 🗌 Separated

Spouse/Partner: Phone Number:

**EMERGENCY CONTACT (not at same address):**

Name: Relationship:

Home Phone: Cell Phone:

**PERPETUAL AUTHORIZATION**

If you would like us to leave you messages regarding your Protected Health Information (PHI), please provide us with your phone number and email address where you prefer our office to leave messages.

Phone number to leave messages: Email Address: Permission to release protected health information to FAMILY MEMBER, CAREGIVER, OR OTHER PERSON:

🗌 I authorize Drs. VanderGriend, Miller, Fredette, and their staff to release information to:

Name: Relationship:

Name: Relationship:

Name: Relationship:

Must check at least one of the following:

🗌 Please Include All Protected Health Information OR **EXCLUDE** ANY OF THE FOLLOWING:

🗌 HIV (AIDS) 🗌 Sexually Transmitted Diseases 🗌 Mental Disorders 🗌 Drug/Alcohol Use

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health-care operations. You have the right to revoke this consent in writing except where we have already made disclosures. I authorize treatment of the person named above and agree to accept full financial responsibility for payment regardless of third party responsibility. I authorize the release of any medical information requested by my insurance company. I authorize payment of medical benefits to Parkway General Surgeons/Parkway Surgery Center. Finance charges may be charged to personal balance accounts over 45 days at the rate of 3% monthly. I authorize vendor representatives to be present at the time of my procedure/surgery when necessary. If cancer is diagnosed by the pathologist, I agree that medical records relating to this cancer may be recorded in the Tumor Registry. I authorize PGS/PSC and my surgeon to take photographs during my procedure/surgery. In the event of an accidental exposure of my blood/ body fluids with another person, I agree to have my blood tested for the Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), and the Hepatitis C Virus (HCV). Advance Directives will not be honored at PGS/PSC.