Parkway General Surgeons/Parkway Surgical Center

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.

PATIENT SIGNATURE:_____DATE:_____

REVIEWED & UPDATED:_____DATE:_____