Surgery Center at St. Andrews
To be completed by patient

Date:_____

Name_____Home Phone #_____

Address_____City/State/Zip_____

Social Security #_____Birthdate_____Sex (Circle) M F

Northern Address(If applicable):_____City/State/Zip:_____

Place of Employment_____ Phone #_____

Address_____City/State/Zip_____

Emergency Contact:_____Phone #:_____Relationship:_____

NAME AND TELEPHONE # OF PERSON PROVIDING TRANSPORTATION TODAY:_____

_____

Spouse's name:_____***Spouse's DOB:***_____

To our patients:
State regulations require us to collect the following racial information for statistical purposes. Please choose a selection from the choices below: *(If you do not wish to disclose this information, select "No Response")*

___Asian ___African American ___Hispanic Non-Caucasian ___Native American

___Caucasian ___Hispanic ___Other ___No Response

Medicare Secondary Payor Screening

1. Are you currently receiving Medicare Benefits? **Yes** No (if "Yes", please answer questions 2,3 & 4)
2. Are either you or your spouse currently working? **Yes** **No**
3. Are either you or your spouse currently provided with any group health coverage? **Yes** **No**
4. Are you currently receiving any other health care benefits (i.e. Black Lung, Veterans Affairs, government program research grant, work, non-work, or automobile accident related injury or illness benefits? **Yes** **No**

Advanced Directives

1. **YES, I DO** **NO, I DO NOT** have an Advance Directive, Living Will, or Health Care Power of Attorney.
   (If YES, then another form will be provided for your review and acknowledgement.)
2. **YES, I DO** **NO, I DO NOT** want to have information on Advance Directives.
   (If YES, then a brochure will be made available to you for your review.)

I have reviewed and agree with the above

_____ _____
Signature of Patient or Responsible Party Date Witness Date