

SURGERY CENTER AT ST. ANDREWS

**We want to make sure that you understand every part of your care today.
If you can read and understand this message, please initial here _____.
If you require a larger font, please ask the receptionist to assist you.**

Name _____
Address _____ City/State/Zip _____
Social Security # _____ Birthdate _____ Sex (Circle) M F
Place of Employment _____ Phone _____
Address _____ City/State/Zip _____
Emergency Contact _____ Phone# _____ Relationship _____
Spouse's Name _____ Spouse's Date of Birth _____

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, please 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, answer 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 healthcare benefits (i.e. Black Lung, VA, government research grant, work or non work related, auto accident related injury or illness benefits?) **YES** **NO**
- 5. Are you currently residing in a Skilled Nursing Facility (SNF)? **YES** **NO**

If YES, what is the date of your admission? _____

ADVANCED DIRECTIVES

- 1. YES, I Do NO, I do not have an Advance Directive Living Will or Healthcare Power of Attorney.
- 2. YES, I Do NO, I do not want information on Advance Directives. (A brochure is available for you)

I have reviewed and agree with the above. _____
Signature of Patient **Date**