

Patient Label

Please Print Information

Legal Last Name: _____ **Legal First Name** _____ **MI** _____

Name identified by your Insurance Card(s): _____

Home Address: _____ Apt # _____

Zip Code _____ City _____ ST _____

SEX: M / F SSN: _____ DOB: _____

Texas law requires the Texas Health Care Information Council to collect information on the race/ethnic backgrounds of hospital patients.

Patient Ethnicity: _____ 1=Hispanic or Latino Origin, 2=Not of Hispanic or Latino Origin

Race: _____ 1=American Indian/Eskimo/Aleut, 2=Asian/Pacific Islander, 3=Black, 4=White, 5=Other race (includes all other responses, not listed above or someone who considers themselves as multiracial or mixed race should choose this category.

Home Phone: _____ Work Phone: _____ Cell number: _____

Marital Status: S M D W Current Employer Name: _____

If self, do not complete this section

Policy Holder(s) if other than Patient/Responsible Party: circle one (spouse / parent / WC/ Other _____)

Name of Policy Holder for: Primary Ins Secondary Ins Tertiary Ins

Last Name: _____ First Name _____ MI _____

SSN: _____ DOB: _____

Home Address: _____ Employer Name & Address: _____

If procedure is due to an **injury**, please provide **Date of Injury / Onset Date / DOA:** _____

For Workers Comp, please provide **employer's name & address:** W/C MVA

Employer Name: _____ Phone : _____
(where injury occurred)

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact(s) of nearest relative(s) or Responsible Party

Name: _____ Phone _____ (H/W/C) Relationship _____

Name: _____ Phone _____ (H/W/C) Relationship _____

Name: _____ Phone _____ (H/W/C) Relationship _____

If you are a repeat patient, please verify your demographics again and let us know of any changes

I have verified all my information and no changes are required at this time _____

Pt's initials _____ Date _____

If changes are required, please complete a new form.

Place Patient Identification Label Here

Privacy Notice and Alternative Communication Acknowledgement

I, *(print patient's name)* _____,

- I acknowledge that I have been offered/received a copy of the Privacy Notice for Surgery Center of Arlington. Privacy Notice Revision Date: April 14, 2003

(AND)
- I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information, but have no such request as of this date. *(If these options are checked, proceed to patient/personal representative signature line below.)*

(OR)
- I request that Surgery Center of Arlington/United Surgical Partners International, Inc. communicate my protected health information with me by the alternative means or at the alternative locations indicated below: *(Complete Alternative Communication form 13520)*
- If Protected Health Information Restriction is requested, complete form 13510.* On the day of your surgery you must be accompanied by a person who will be able to receive post-operative instructions on your behalf in the event that you are unable to do so as a result of your anesthesia. For your safety, we will not be able to honor a request to restrict information about your care from this person. Please consider this as you decide who will accompany you on your day of surgery.

Patient or Personal Representative Signature

Date

Printed Name of Patient or Personal Representative

Personal Representative's Relation to Patient

Admission's Employee Signature

Date

ABOVE - Patient or Personal Representative Use Only

Below - Provider Use Only Documentation of Good Faith Effort

The patient identified above was provided with a copy of the Provider's Privacy Notice on this date. A good faith effort has been made to obtain a written acknowledgement of the patient's receipt of the Privacy Notice. However, acknowledgement has not been obtained because:

- Patient refused to sign the Privacy Notice Acknowledgement
- Patient was unable to sign because: _____
- There was a medical emergency. Provider will attempt to obtain acknowledgement as soon as practical.
- Other reason, described below: _____

Administrator Signature

Date