

PATIENT INTAKE FORM

OFFICE USE ONLY
Photo Identification _____

PATIENT INFORMATION

Last Name _____ First Name _____ MI _____
SSN _____ - _____ - _____ Date of Birth ____ / ____ / ____ Age _____ Patient Account # _____
Marital Status: SINGLE MARRIED DIVORCED WIDOWED Gender: MALE FEMALE
Address _____ City _____ State _____ Zip _____
Home Phone _____ - _____ - _____ Mobile Phone _____ - _____ - _____ Other _____ - _____ - _____

EMPLOYER INFORMATION

Employment Status: FULL-TIME PART-TIME STUDENT UNEMPLOYED RETIRED CHILD OTHER _____
Employer _____ Job Title _____
Employer Address _____ Work Phone _____ - _____ - _____
City _____ State _____ Zip _____

PRIMARY INSURANCE INFORMATION

Last Name _____ First Name _____ MI _____ Date of Birth ____ / ____ / ____
SSN _____ - _____ - _____ Relationship to Patient: SELF SPOUSE PARENT OTHER _____
Employer _____
Insurance Company / Policy _____ Telephone _____ - _____ - _____
Policy Number _____ Subscriber / Member ID _____
Group Name / Number _____ On-the-Job Injury: YES NO Motor Vehicle Accident: YES NO
Worker's Comp Claim Number _____ Date of Injury ____ / ____ / ____ State _____
Worker's Comp Contact Name _____ Telephone _____ - _____ - _____

SECONDARY INSURANCE INFORMATION

Last Name _____ First Name _____ MI _____ Date of Birth ____ / ____ / ____
SSN _____ - _____ - _____ Relationship to Patient: SELF SPOUSE PARENT OTHER _____
Employer _____
Insurance Company / Policy _____ Telephone _____ - _____ - _____
Policy Number _____
Subscriber / Member ID _____ Group Name / Number _____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Name _____ Date of Birth ____ / ____ / ____ SSN _____ - _____ - _____
Address _____ City _____ State _____ Zip _____
Employer _____ Telephone _____ - _____ - _____
Address _____ City _____ State _____ Zip _____

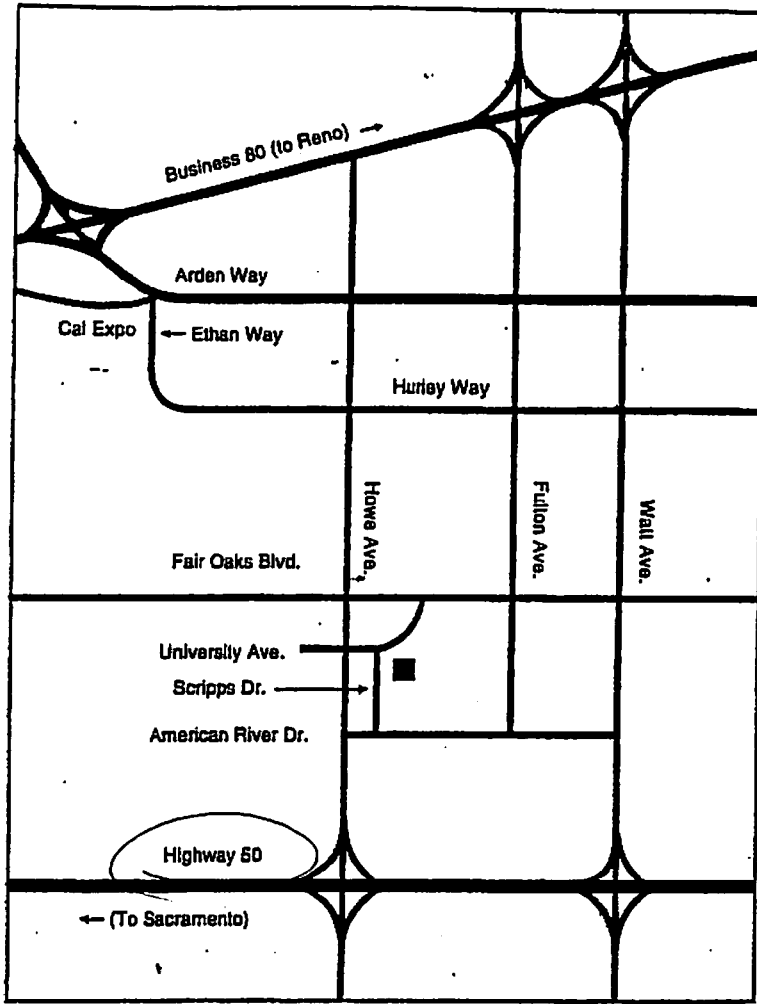
EMERGENCY CONTACT INFORMATION

Name _____ Relationship to Patient: _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ - _____ - _____ Mobile Phone _____ - _____ - _____ Other _____ - _____ - _____

I understand that my primary insurance will be filed, and if no payment is made within 45 days, I will be responsible for the balance. I have reviewed the above information and verify that it is accurate.

Patient Signature _____ Date ____ / ____ / ____
Witness Signature _____ Date ____ / ____ / ____

NAME OF PERSON DRIVING YOU HOME: _____
WILL BE HERE _____
NEED TO CALL - PHONE # _____



**DIRECTIONS TO
HEALTHSOUTH SURGERY CENTER - SCRIPPS**

HEALTHSOUTH Surgery Center is located at 75 Scripps Drive, near the intersection of Howe Avenue and Fair Oaks Boulevard in Sacramento. Parking is available across the street. There is a patient loading zone at the front door. Doors are open from 6:00a.m. to 5:00p.m., Monday through Friday.

Sutter River City Surgical Center

an affiliate of **SCA**

ASC Conditions of Coverage Patient Attestation

Patient Name: _____

Date of Procedure: _____

I certify that I have received written documentation of the following items, in advance of the date of my scheduled procedure:

1. Patient's Rights and Responsibilities
2. Advance Directives
3. Disclosure of Physician Ownership

Furthermore, I understand that this information is being provided for my benefit and that should I have any questions regarding its content, I should contact the Center for clarification.

Patient Signature

Date

HHH TO OUR PATIENTS HHH

The California Health and Safety Code (Section 128737) requires that we collect and submit the following information to the Office of Statewide Health Planning & Development beginning January 1, 2005. We have all of the information except 'Race', 'Ethnicity' and 'Principle Language Spoken.'

- | | |
|--|--|
| <ul style="list-style-type: none"> ● Patient social security number ● ZIP code ● Date of birth ● Sex ● Race ● Ethnicity ● Date of service ● Other procedures (CPT-4) | <ul style="list-style-type: none"> ● Disposition of patient ● Expected source of payment ● Principal diagnosis ● Other diagnoses ● Principal E-code ● Other E-code ● Principal procedure (CPT-4) ● Principle Language Spoken |
|--|--|

For text of the law, visit the California Legislative Information web site at www.leginfo.ca.gov.

Are you here as the result of an injury? YES NO

If you marked 'Yes,' where did the injury occur (i.e. home, work, school)?

How did it occur?

Please mark 1 box in each section below. Thank you.

| RACE | PRINCIPLE LANGUAGE SPOKEN | |
|--|--|--|
| <input type="checkbox"/> American Indian (R1) <input type="checkbox"/> Asian (R2) <input type="checkbox"/> Black/African American (R3) <input type="checkbox"/> Native Hawaiian/Pacific Islander (R4) <input type="checkbox"/> White (R5) <input type="checkbox"/> Other Race (R6) <input type="checkbox"/> Unknown (99) | <input type="checkbox"/> ENG English (06) <input type="checkbox"/> ARA Arabic (01) <input type="checkbox"/> ARM Armenian (02) <input type="checkbox"/> KHM Cambodian (03) <input type="checkbox"/> CHI Chinese (04) <input type="checkbox"/> SCR Croatian (05) <input type="checkbox"/> FRE French (07) <input type="checkbox"/> CPF French Creole (08) <input type="checkbox"/> GER German (09) <input type="checkbox"/> GRE Greek (10) <input type="checkbox"/> GUJ Gujarathi (11) <input type="checkbox"/> HEB Hebrew (12) <input type="checkbox"/> HIN Hindu (13) <input type="checkbox"/> HMN Hmong (14) <input type="checkbox"/> HUN Hungarian (15) <input type="checkbox"/> ITA Italian (16) <input type="checkbox"/> JPN Japanese (17) <input type="checkbox"/> KOR Korean (18) <input type="checkbox"/> LAO Laotian (19) <input type="checkbox"/> HMN Miao (20) <input type="checkbox"/> KHM Mon-Khmer (21) | <input type="checkbox"/> NAV Navajo (22) <input type="checkbox"/> PER Persian (23) <input type="checkbox"/> POL Polish (24) <input type="checkbox"/> POR Portuguese (25) <input type="checkbox"/> RUS Russian (26) <input type="checkbox"/> SCR Serbian (27) <input type="checkbox"/> SPA Spanish (28) <input type="checkbox"/> TGL Tagalog (29) <input type="checkbox"/> THA Thai (30) <input type="checkbox"/> URD Urdu (31) <input type="checkbox"/> VIE Vietnamese (32) <input type="checkbox"/> YID Yiddish (33) <input type="checkbox"/> Unknown (999) |
| <p>ETHNICITY</p> <input type="checkbox"/> Hispanic/Latino (E1) <input type="checkbox"/> Non-Hispanic/Non-Latino (E2) <input type="checkbox"/> Unknown (99) | | |

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES***

You may refuse to sign this acknowledgement

*Sutter River City will use and disclose your personal health information to treat you.
To receive payment for the care we provide, and for other health care operations.
Healthcare operations generally include those activities we perform to improve the quality of
care.*

*We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand
our policies about your personal health information.
The terms of the notice may change with time and we will always post the current notice at our
facilities, on our website, and have copies available for distribution.*

I, _____, have received a copy of this
facility's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but the
acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

Include completed consent in the patient's Medical Record