THE SURGICAL CENTER OF MIDLAND
ADMISSIONS INFORMATION

Patient Name: ___________________________ Date of Birth: ____________ Age: _______

Address: ____

City: ___________________________________ State: ___________ Zip: _______________

Home Phone: __________________________ Work Phone: __________________________

Employer: ____________________________

Marital Status: ____ Married ____ Single ____ Widow ____ Divorced

Race/Ethnicity: ____Caucasian ____Hispanic ____African-American/Black

____ Asian/Pacific Islander ____American Indian/Eskimo ____Other

Do you have an Advanced Directive? : ____ yes ____no

If so, please provide a copy as part of your medical records.

In case of an emergency, please notify: ____

Phone Number: ______________________________ Relation to you: __________________

Patient's Social Security #: ___________________________________

(This is not always the same as your Medicare #)

Assignment of Benefits

I authorize payment of medical benefits to the undersigned physicians or supplier for service described below. I authorize the release of any medical information necessary to process this claim. I also request payment of government benefits either to myself or the party who accepts assignment.

Signature: _______________________________________ Date: ______________________