ST. GEORGE SURGICAL CENTER

PATIENT INFORMATION			INSURED PERSON INFORMATION		
Name: Last	First	Middle	**Name:** Last	First	Middle
Address			Address		
City	State	Zip	City	State	Zip
Preferred Phone Number		**Alternate Phone Number**	**Preferred Phone Number**		**Alternate Phone Number**
Gender (circle one) Female Male Other	**Date of Birth** **Soc. Sec. #**		**Gender** (circle one) Female Male Other	**Date of Birth** **Soc. Sec. #** **Relationship to patient**	

Patient Race (circle one)

American Indian/Alaska Native Asian Black/African American Native Hawaiian/other Pacific Islander White

Ethnicity (circle one)

Hispanic or Latino
Not Hispanic or Latino

Patient Marital Status (circle one)

Married Unmarried Divorced Legally Separated Domestic Partner Widowed Polygamous

Name of other contact/ relationship **Phone**

Address

PATIENT EMPLOYMENT INFORMATION			INSURED PERSON EMPLOYMENT INFORMATION		
Employer			Employer		
Address			Address		
City	State	Zip	City	State	Zip
Work Phone		Full Time Employed Part Time	Work Phone		Full Time Employed Part Time

We will need a copy of ALL insurance cards and a valid Picture ID.

PRIMARY INSURANCE INFORMATION		SECONDARY INSURANCE INFORMATION	
Insurance Company		Insurance Company	
Policy Holder	Date of Birth	Policy Holder	Date of Birth
Policy # or ID #	Group #	Policy # or ID #	Group #
Address of Insurance Company		Address of Insurance Company	
Phone number of Insurance Company		Phone number of Insurance Company	

I, the undersigned, do attest as either Patient or representative of the Patient that the above information is accurate to the best of my knowledge.

Signature:_____**Date:**_____**Relationship to Patient**_____