PATIENT INFORMATION FORM

PLEASE **PRINT** AND COMPLETE ALL ITEMS **FRONT & BACK**

PATIENT'S NAME: _____ **SEX:** _____ **DOB:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

PHONE#: _____ **ALT PHONE#:** _____ **EMAIL:** _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

WORK STATUS: ☐ RETIRED ☐ WORKING ☐ DISABLED

Referring Physician: _____ **Primary Care Physician:** _____

******IF PATIENT IS UNDER THE AGE OF 18 PLEASE FILL OUT BELOW******

GUARDIAN NAME	RELATIONSHIP	DOB	SSN#	PHONE#

AGREEMENT FOR PAYMENT OF BALANCE DUE

I hereby authorize payment directly to The Surgical Pavilion, 9500 Kanis Road, Suite 401, Little Rock, AR 72205, for the services provided to me on this date and otherwise payable to me. I understand that any estimated amount collected today is only an estimate and does not constitute payment in full. I agree that I will be responsible for any allowed charges not paid by my insurance. I agree that I will be held liable for any collection, legal or court cost should it become necessary for The Surgical Pavilion to pursue these avenues to collect a balance due.

Patient Signature:_____ Date: _____ Time: _____

Responsible Party Signature:_____ Date: _____ Time: _____

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AUTHORIZATION TO DISCLOSE INFORMATION

I, _____, hereby authorize The Surgical Pavilion, LLC
Patient Name
to release my medical information (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, etc.) to the following family members (ID required for pick-up):

NAME	DOB	RELATIONSHIP

I reserve the right to withdraw this authorization at any time.

_____ _____

Patient/Legal Guardian Signature Date of Signature

NOTE: **If patient is unable to sign, individual signing must present information satisfactory to institution releasing information that individual is legally responsible for patient. Signature will be verified by personnel of authorized institution to release information.**