

**Welcome to MID-OHIO SURGICAL ASSOCIATES, INC.**  
**PATIENT INFORMATION FORM: Please Print**

**Patient**

Last Name \_\_\_\_\_ Email Address \_\_\_\_\_  
Home Phone # \_\_\_\_\_ Cell: \_\_\_\_\_  
First Name \_\_\_\_\_ MI. \_\_\_\_\_ Work Phone # \_\_\_\_\_ Ext. \_\_\_\_\_  
Street \_\_\_\_\_ Date of Birth \_\_\_\_\_ Birth State \_\_\_\_\_  
City/State \_\_\_\_\_ Social Security # \_\_\_\_\_  
Zip \_\_\_\_\_ Sex - M F \_\_\_\_\_ Marital Status \_\_\_\_\_  
Employed? Yes No \_\_\_\_\_ Employer \_\_\_\_\_

**Spouse**

Last Name \_\_\_\_\_ Home Phone # \_\_\_\_\_  
First Name \_\_\_\_\_ MI. \_\_\_\_\_ Work Phone # \_\_\_\_\_ Ext. \_\_\_\_\_  
Street \_\_\_\_\_ Date of Birth \_\_\_\_\_ Birth State \_\_\_\_\_  
City/State \_\_\_\_\_ Social Security # \_\_\_\_\_  
Zip \_\_\_\_\_ Sex - M F \_\_\_\_\_ Marital Status \_\_\_\_\_  
Employed? Yes No \_\_\_\_\_ Employer \_\_\_\_\_

**Emergency Contact Other Than Spouse**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**Insurance Information** (provide receptionist with current insurance cards and complete the following)

Primary Coverage \_\_\_\_\_ Secondary Coverage \_\_\_\_\_  
Claim Address \_\_\_\_\_ Claim Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Policyholder: Self Spouse Other \_\_\_\_\_ Policyholder: Self Spouse Other \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Date of Birth \_\_\_\_\_  
I.D.# \_\_\_\_\_ I.D.# \_\_\_\_\_  
Group # \_\_\_\_\_ Group # \_\_\_\_\_  
Is Plan Through Work: Yes No \_\_\_\_\_ Is Plan Through Work: Yes No \_\_\_\_\_

**(Your insurance carrier MAY require you to obtain a referral from your primary care physician prior to your visit. Services will not be covered without it. If you have a referral or are unsure if you require a referral please see the receptionist.)**

**Who is your family doctor?**

Doctor's Name \_\_\_\_\_

Doctor's Address \_\_\_\_\_ Phone # \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

**History** Indicate the year you last received a:

Pneumonia Shot \_\_\_\_\_ Cholesterol Test \_\_\_\_\_  
Hepatitis Vaccine \_\_\_\_\_ TB Test \_\_\_\_\_  
Tetanus Shot \_\_\_\_\_ Eye Exam \_\_\_\_\_  
Flu Vaccine \_\_\_\_\_ Rectal Exam \_\_\_\_\_  
Sigmoid Exam \_\_\_\_\_ Stool Blood Test \_\_\_\_\_  
PSA \_\_\_\_\_

**For Women Only**

Age at onset of menstrual period \_\_\_\_\_ # of pregnancies \_\_\_\_\_  
Date of last menstrual period \_\_\_\_\_ # of live births \_\_\_\_\_  
Birth control type \_\_\_\_\_ # of abortions \_\_\_\_\_  
# of miscarriages \_\_\_\_\_

**Year of last:**

Breast Exam \_\_\_\_\_ normal or abnormal  
Mammography \_\_\_\_\_ normal or abnormal  
Pap \_\_\_\_\_ normal or abnormal

**Health Concerns/Reason for Visit**

Name of relative/care giver to discuss Medical treatment. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

I authorize the physicians of Mid-Ohio Surgical Associates, Inc. to provide any medical care deemed necessary according to their professional opinion. I understand that I am financially responsible for this account unless other arrangements have been made. I request that payment of authorized insurance and/or Medicare benefits be made directly to Mid-Ohio Surgical Associates, Inc. authorize release to the Health Care Financing Administration and/or my insurance carrier and its agents any medical information about me to determine the payments for related services.

The NOTICE OF PRIVACY PRACTICE has been made available to me in accordance with the Privacy Rule in 45 C.F.R. Part 164.520.

X Legal Signature \_\_\_\_\_ Date \_\_\_\_\_