

# Welcome To Our Office!

## Plainview Surgical Care

### Dr. Cummins

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Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
          First                          Middle                          Last

SSN: \_\_\_\_\_ Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Telephone: (    ) \_\_\_\_\_ Cell phone: (    ) \_\_\_\_\_  
Work phone: (    ) \_\_\_\_\_ Email Address: \_\_\_\_\_

In case of emergency, contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: (    ) \_\_\_\_\_ Work Phone: (    ) \_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_

Which Pharmacy do you use? \_\_\_\_\_

May we search your pharmacy for a list of your current medications? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If your insurance in the name of your spouse or parent:

Name of Insured: \_\_\_\_\_ Birth date: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts. See our complete financial policy for details.

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. This office discloses medical information to family member unless you request otherwise. I understand that I am entitled to receive a copy of this document.

- No changes.
- I do not want family to be given my personal medical information.
- I would like the following, **non-family** members, added to my list of contacts.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Print Name of Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative