TOWER CLOCK SURGERY CENTER

Patient Information Sheet

PERSONAL INFORMATION

Last Name	First Name	MI	Date of Birth	Age
Street Address/ P.O. Box	**City**	**State**	**Zip Code**	
Social Security Number	**Home Phone Number** (______) _________-_________		**Cell Phone Number** (______) _________- _________	
Employer (if applicable)	**Work Phone Number** (______) _________-_________			
Spouse Name	**Spouse Contact Number** (______) _________-_________			

Sex	Race
☐ Male ☐ Female	☐ American Indian ☐ Asian ☐ African American or Black ☐ Native Hawaiian ☐ White ☐ Multiracial
Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced	**Ethnicity** ☐ Hispanic ☐ Non-Hispanic

CONTACT INFORMATION (Outside of Household)
Name
Relationship to Patient
Telephone Number Home (______) _________-_________ Cell (______) _________-_________

Primary Insurance	Policy Number	Subscriber	Relationship to Patient ☐ Self ☐ Spouse DOB:_____ ☐ Other _____________
Secondary Insurance	**Policy Number**	**Subscriber**	**Relationship to Patient** ☐ Self ☐ Spouse DOB:_____ ☐ Other _____________
Name of Primary Care Provider		**Place of Practice**	

TOWER CLOCK SURGERY CENTER

LEGAL GUARDIANSHIP INFORMATION (If Applicable)

Last Name	First Name	MI	Relationship to Patient
Street Address/ P.O. Box	City	State	Zip Code
Social Security Number	Home Phone Number (______) _________-_________		Cell Phone Number (______) _________-_________

See Reverse Side. Signature Required

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed the Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient/Legal Guardian Date