Pulaski Surgery Clinic, P.A. 3401 Springhill Drive, Ste 400* North Little Rock, AR 72117* (501) 945-4422 phone * (501) 945-4424 fax

PATIENT INFORMATION (PLEASE **PRINT**)

Dr. Stair / Dr. DeLoach/ Dr. Hayes/ Dr. Bevans III/ Dr. Shaw (Please circle which doctor you are seeing)

Patient's Name ____ **Date of Birth** ____________________ **Age**______________

Address____**City** ______________________ **State** ______**Zip**___________

Home Phone____**Cell Phone**_________________**SS#**______________________

E-mail address____

Sex_____**Race** ________ **Ethnicity** __________ **Marital Status** _________ **Referring Physician**________________________________

Employer____**Phone**_______________________________**Ext** ____________

Employer Address_______________________________________**City**______________________ **State** _____**Zip**____________

Spouse's Name (or Parent's name if Minor)____**SS#** ______________________

Spouse's/ Parent's Employer ______________________________ **Phone**_______________________________**Ext** _____________

Next of Kin, Not in the same household ________________________________ **Phone** ____________________________________

Address ____ **City** ____________________ **State**_____ **Zip** _____________

Emergency Contact____**Phone** ______________________________________

Have you ever been seen by any of our doctors? If yes, which doctor? ____
Please state when and where:____

ARE YOU BEING SEEN FOR A WORK RELATED INJURY? **YES NO** DATE OF INJURY:___________________________
WAS YOUR EMPLOYER NOTIFIED? **YES NO**

Primary Care Physician____

** PRIMARY INSURANCE ____
Address ____ City ____________________State ____ Zip ____
Subscriber Name ___________________________ Date of Birth _______________
ID # ____/ Group# ____

** SECONDARY INSURANCE ____
Address ____ City ____________________State ____ Zip ____
Subscriber Name ___________________________ Date of Birth _______________
ID # ______________________________________ / Group# ____

I authorize release of any medical information necessary to process all insurance claims. I understand and acknowledge primary responsibility for the medical fees not covered by insurance. I hereby authorize payment directly to the above named physician of the group insurance benefits otherwise payable to me. I also authorize release of medical records from North Metro Medical, Baptist Health, St. Vincent, North River Surgery and Springhill Surgery Center.(Signatures of patient if minor, parent or guardian please sign.)

Signed: ____ Date _____________________

Medicare Authorization Only

I request that payment of authorize Medicare benefits be made either to me or on my behalf to Drs. Stair, DeLoach, Hayes, Bevans III or Shaw for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signed:__________________________ ____ ___ Date____________________ __