AGAVE SURGICAL ASSOCIATES, P.C.
Patient Demographics Form
(Please print clearly and complete all lines)

Date: _____

Name: _____ Alias: _____
Last First Middle

Social Security#:___-___-___ Date of Birth: ___-___-___ Age: ___ Gender: M or F

Street Address: _____ Apt# _____

City: _____ State: _____ Zip: _____ County: _____

PO Box: _____ City: _____ State: _____ Zip: _____

Race: _____ Preferred Language: _____ Ethnicity: _____
Birth State: _____ Country of Origin: _____

Marital Status: Married Single Widow Divorced

Home Phone: ( ) _____ Cell Phone: ( ) _____

Email: _____ Preferred Pharmacy: _____
_____
_____

Primary Care Physician: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Employment Information
Employment Status: (Please circle one)
Employed Student Not Employed Retired Self Employed Military

Employer Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone#: ( ) _____ Occupation: _____

Emergency Contact:
Name: _____ Relationship: _____
Legal Guardian: Yes or No
Address: _____ City: _____ State: _____ Zip: _____
Phone#: ( ) _____

Patient Insurance Information

Is this due to an on the job injury? Yes or no If yes, the date of injury: ____-____-___

Employer at the time of injury: _____ Phone #: ( ) _____
PLEASE PROVIDE US WITH A COPY OF THE CLAIM REPORT SHOWING THE CLAIM NUMBER AND ISURANCE CARRIER.

Guarantor information: (For a minor or person/entity financially responsible, if other than the patient):
Name: _____
Last First Middle

Relationship: _____ Phone #: ( ) _____
Street Address: _____ Apt#: _____
City: _____ State: _____ Zip: _____ County: _____
Social Security #: _____-_____-_____ Date of Birth: _____-_____-_____

Primary Insurance: PLEASE PRESENT INSURANCE CARD AND PHOTO I.D.
Name of Coverage Plan: _____
Name of Policy Holder: _____ Relationship to Patient: _____
Insurance/Member ID: _____ Group# (if any): _____ Through Employer: Yes or No
Social Security # of Policy Holder: _____-_____-_____

Secondary Insurance:
Name of Coverage Plan: _____
Name of Policy Holder: _____ Relationship to Patient: _____
Insurance/Member ID: _____ Group#: (if any): _____ Through Employer: Yes or No
Social Security # of Policy Holder: _____-_____-_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I, the undersigned, authorize Agave Surgical Associates and its affiliates (Provider) to release my medical records to any referring or referred physician and my primary care. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I further agree to physician orders and associated diagnoses being sent via fax or electronic submissions, to other physicians, hospital, pharmacies and/or other diagnostic/treatment facilities. I authorize payment under my medical insurance program to be made directly to Agave Surgical Associates and I further authorize Agave Surgical Associates to release to my medical insurance company any confidential medical information which may be considered instrumental and payment of my medical claim.

Patient's Signature: _____ Date: _____