Bloomfield Hills Surgical CENTER

Patient's Name: _____

Patient's Home Phone Number: _____Alternate Phone Number (☐ cell or ☐ work): _____

E-mail Address: _____ Social Security _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Emergency Contact: _____

Relationship to Patient: _____

Phone number: _____

Patient's Employer: _____

Employment Status: ☐ Full time ☐ Part time ☐ Unemployed

☐ Retired ☐ Student ☐ Other: _____

INSURANCE INFORMATION- We will request to scan your ID & Insurance Card

Primary Insurance: _____
Contract ID number: _____
Patient Policy Holder ☐ Yes ☐ No

Secondary Insurance: _____
Contract ID number: _____
Patient Policy Holder ☐ Yes ☐ No

INSURED INFORMATION (IF OTHER THAN PATIENT)

Subscriber/Policy Holder: _____
Relationship to Patient: _____
Address: _____
Date of Birth**:** _____
His or Her Employer: _____

RELEASE OF INFORMATION

I hereby give permission to the person(s) listed below to receive information about the care of the above-named patient.

Names(s):_____ Relationship to Patient: _____

Signature: _____ ☐Patient ☐Parent of Minor ☐Legal Representative

Date:_____