World Class Physicians. Hometown Care
HIGH PLAINS
SURGERY CENTER

DATE OF SURGERY | PHYSICIAN | MEDICAL RECORD # | DATE OF PRE-OP VISIT

PATIENT INFORMATION

Patient NAME (LAST, FIRST, MIDDLE) | SOCIAL SECURITY NUMBER

DATE OF BIRTH | AGE | SEX | RACE | MARITAL STATUS

MAILING ADDRESS (CITY, STATE AND ZIP) | PHONE NUMBER

RESIDING ADDRESS (IF DIFFERENT) | CELL PHONE NUMBER

EMAIL ADDRESS

EMPLOYER

EMPLOYER'S ADDRESS (CITY, STATE AND ZIP) | EMPLOYER'S PHONE NUMBER

GUARANTOR/RESPONSIBLE PARTY | SOCIAL SECURITY NUMBER | RELATIONSHIP

GUARANTOR/RESPONSIBLE PARTY'S MAILING ADDRESS (CITY, STATE AND ZIP) | PHONE NUMBER

GUARANTOR/RESPONSIBLE PARTY'S EMPLOYER

GUARANTOR/RESPONSIBLE PARTY'S EMPLOYER'S ADDRESS (CITY, STATE AND ZIP) | EMPLOYER'S PHONE NUMBER

PERSON TO CONTACT IN AN EMERGENCY **(WHO DOES NOT LIVE WITH YOU)**

ADDRESS (CITY, STATE AND ZIP) | PHONE NUMBER

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER | POLICY OWNER'S NAME | SOCIAL SECURITY NUMBER | DATE OF BIRTH

INSURANCE ID NUMBER | GROUP NUMBER | GROUP NAME

MAILING ADDRESS (CITY, STATE AND ZIP)

SECONDARY INSURANCE CARRIER | POLICY OWNER'S NAME | SOCIAL SECURITY NUMBER | DATE OF BIRTH

INSURANCE ID NUMBER | GROUP NUMBER | GROUP NAME

MAILING ADDRESS (CITY, STATE AND ZIP)

OTHER INFORMATION

IS THIS A WORK-RELATED INJURY? _ YES _ NO

IF "YES", PLEASE PROVIDE THE INFORMATION BELOW.

DATE OF INJURY | DATE REPORTED TO EMPLOYER | SUPERVISOR'S NAME

EMPLOYER | EMPLOYER ADDRESS | TELEPHONE NUMBER

EMPLOYER'S WORKERS COMPENSATION INSURANCE COMPANY | FILE/CLAIM NUMBER