Bay Surgery Center
6633 Telegraph Avenue, Suite B
Oakland, CA 94609

PATIENT INITIAL VISIT INFORMATION SHEET

PERSONAL INFORMATION:

Name _____ Date _____
Last First Middle Initial

Address _____ Phone (_____) _____
Street

_____ Social Security Number: _____
City State Zip

E-mail Address _____ Fax (_____) _____

Birth date _____ Age _____ Sex _____ Driver's License # _____

Date of Injury/Accident _____ How did it happen? _____
SPECIFIC DATE PLEASE

Auto ☐ Sports ☐ Work ☐ Other ☐

CURRENT EMPLOYER:

☐ Not Applicable

Employer _____ Phone (_____) _____

Address _____
Street City State Zip

Occupation _____ Supervisor _____

Employer E-mail Address _____ Fax (_____) _____

INSURANCE (private or commercial insurance only):

Name of Insured _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Insured date of birth _____ Insured SSN _____

EMERGENCY CONTACT (Closest friend or relative NOT living with you):

Full Name _____ Relationship _____ Phone (_____) _____

Address _____
Street City State Zip

General Medical Consent: The patient or the patient's legal representative hereby consents to general and medical care, including but not limited to x-ray examinations, laboratory procedures and medical services rendered to the patient under the general and special instructions of the physician. It is understood that the patient is under the care and supervision of his or her attending physician.

Release of Information: To the extent necessary to determine insurance benefits, liability for payment and to obtain reimbursement, we may disclose portions of the patient's medical record and account file to any person or corporation which may be liable for any or all portions of the patients charges, including but not limited to insurance companies, health care service plans or worker's compensation carriers. A complete HIPAA form is available upon request.

Assignment of Insurance Benefits: I authorize the filing of insurance claims on my behalf for services rendered. I also authorize payments to be made directly to this facility for any benefits, both basic and major medical, otherwise payable to or on behalf of the patient for all services rendered.

_____ _____
Signature of patient, parent, legal guardian or legal representative Date

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PATIENT REQUIRED INFORMATION SHEET

Surgery centers and hospitals are **required** by law to provide the Office of Statewide Health Planning and Development (OSHPD) with information regarding the sex, race and ethnicity of their patient population. The mission of OSHPD is to plan for and support the development of a healthcare system that meets the current and future healthcare needs of the people of California. In doing so, we ask that you assist us in providing this information by making the most appropriate selection regarding sex, race and ethnicity from the choices listed below:

Today's Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: _____ Other Telephone: _____

Birth date: _____ Social Security Number: _____

Sex (*please check one*):
☐ Female ☐ Male

RACE (*please check one*):

☐ **American Indian or Alaska Native:** A person having origins in or who identifies with any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.

☐ **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ **Black or African American:** A person having origins in or who identifies with any of the black racial groups of Africa.

☐ **Native Hawaiian or Other Pacific Islander**: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ **White:** A person having origins in or who identifies with any of the original Caucasian peoples of Europe, North Africa, or the Middle East.

☐ **Other Race:** Any possible options not covered in the above categories. This includes patients who cite more than one race.

☐ **Unknown:** A person who cannot or refuses to declare race.

ETHNICITY *(please check one)*:

☐ **Hispanic or Latino:** A person who identifies with or is of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin.

☐ **Non-Hispanic or Non-Latino:** Any possible options not covered in the above category.

☐ **Unknown:** A person who cannot or refuses to declare ethnicity.