SURGICAL GROUP OF GAINESVILLE

NORTH FLORIDA REGIONAL HEALTHCARE

PLEASE PRINT CLEARLY DATE _____

WHO IS YOUR PRIMARY DOCTOR? _____

PATIENT NAME (Last)_____(First)_____(MI)_____

PREFERRED FULL NAME (if different from above)_____SS# _____

DOB_____/_____/_____ AGE_____ GENDER IDENTITY _____ EMAIL_____

PHONE (Landline) (_____)_____CELL PHONE (_____)_____

LOCAL ADDRESS_____ CITY_____ STATE FL ZIP_____

PREFERRED LANGUAGE: _____ MARITAL STATUS: ____MARRIED ____SINGLE ____OTHER

RACE _____ _____ ETHNICITY: _____ HISPANIC OR LATINO _____ NOT HISPANIC OR LATINO

EMPLOYED (PLEASE LIST EMPLOYER)_____ PHONE # (_____) _____

IF UNDER 18, MOTHER'S NAME_____SSN_____DOB_____PHONE(____)_____

IF UNDER 18, FATHER'S NAME_____SSN_____DOB_____PHONE(_____)_____

NAME OF SCHOOL_____ _____FULL-TIME STUDENT _____PART-TIME STUDENT

SPOUSE'S NAME_____PLACE OF EMPLOYMENT _____

WHERE AND WHEN HAVE YOU LIVED AND TRAVELED OUTSIDE THE U.S. AND CANADA? _____

PHARMACY _____

INSURANCE NAME_____

POLICY NUMBER_____GROUP NUMBER_____

INSURED'S NAME _____INSURED'S COMPANY_____

ADDRESS ON INSURANCE CARD_____

PHONE NUMBER FOR ELIGIBILITY ON BACK OF INSURANCE CARD_____

DO YOU HAVE A LIVING WILL / ADVANCED DIRECTIVE
(Circle One)
☐ YES ☐ NO

In case of emergency please notify (Someone who does not live in your home) Relationship _____

Name_____ PHONE _____

ADDRESS _____

1143 NW 64th Terrace * Gainesville FL * 32605
Phone: 352-331-1201 * Fax: 352-331-5273