

THE SURGERY CENTER OF SANTA ROSA*An affiliate of SCA*

1111 Sonoma Ave., Santa Rosa, CA 95405

707-578-4100 fax 707-578-7997

Patient Sticker on Arrival

Please COMPLETE and sign this form and return it to the facility by mail or fax. Please bring your insurance card(s) with you as well as a valid drivers license or other picture ID on the day of surgery.

1. PATIENT INFORMATION

Date of Sugery ____/____/____ Surgeon _____

Name of Patient _____
Last First Middle NicknameAddress _____
Street City State Zip

Home Telephone _____ Cell Phone _____ Work Telephone _____

Social Security # _____ CDL# _____

Date of Birth ____/____/____ Female Male Marital Status: S M D W

Employer _____ Occupation _____

Emergency Contact _____ Telephone Number _____

Have you been a patient at this facility before? Yes No

If yes, date of last admission _____ Surgeon's Name _____

2. BILLING INFORMATION – Name of person assuming financial responsibility. Parent information if patient is child/minor._____
Last First Middle Birthdate _____Address _____
Street City State Zip

Home Telephone _____ Work Telephone _____

Relationship to Patient _____ Social Security # _____

Employer _____ CDL# _____

Occupation _____ Employer's Address _____
_____**3. SPOUSE'S NAME** _____ Spouse's Work Telephone _____

Spouse's Social Security # _____ CDL# _____ Birthdate _____

4. INSURANCE INFORMATION - Please bring insurance card(s) with you on the date of surgery.

Name of Insurance Company _____

Address _____
Street City State Zip

Telephone _____ Date of Injury if Workers' Comp Claim _____

Policy, SS#, and/or I.D.# _____ Group # _____

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IF you have secondary insurance, please complete the following questions:

Name of Insured Person _____ Insured's Employer _____

Name of Insurance Company _____

Address _____
Street City State Zip

Telephone _____

Policy, SS#, and/or I.D.# _____ Group # _____

The California Health and Safety Code (Section 128737) requires that we collect the following information for the Office of Statewide Health Planning & Development.

Are you here as the result of an injury? No Yes

If you marked "Yes", where did the injury occur (i.e. home, work, school)? _____

How did it occur? _____

- Race: American Indian
 Asian
 Black/African American
 Native Hawaiian/Pacific Islander
 White
 Other Race
 Unknown

- Ethnicity : Hispanic/Latino
 Non-Hispanic/ Non-Latino
 Unkown

Primary Language Spoken _____

If you have Medicare or Medicare HMO Insurance: Retirement Date _____ Spouse Retirement Date _____

Entitled to Medicare due to End Stage Renal Disease? No Yes Date Dialysis started _____

Entitled to Medicare due to Disability? No Yes Date Disability began _____

Covered under V.A. for service connected disability? No Yes

Entitled to Black Lung or other Federal Benefits? No Yes

Patient/Guardian Signature _____ **Date** _____