PRAIRIE STATES SURGICAL CENTER

2908 E. 26th Street ◆ Sioux Falls, SD 57103

Appointment Date ____________ Time __________

Chart ______________________________

Account ______________________________

Patient Name (please print)

____
First Middle In. Last

Address ______________________________

City ________________ State ____ Zip ________

Social Sec. # ______________________________

Home Phone ______________________________

Cell Phone ______________________________

Date of Birth ____________ Gender ______ Age _____

E-mail ______________________________

Emloyer ______________________________

Address ______________________________

City ________________ State ____ Zip ________

Work Phone ______________________________

Parent or Guardian Name if Under 18 years of age:

______________________ Work/Cell # __________

Why are you seeing the doctor today? ______________

____

Current problem is the result of a:

❑ Motor Vehicle Accident ❑ Work Related Injury

❑ Liability ❑ Other

Date of Injury ______________________________

State in which injury occurred ________________

Name of Person **"not living with you"** to contact in case of emergency:

____

Work Phone ______________________________

Hm/Cell Phone ____________ / ____________

Address ______________________________

City ________________ State ____ Zip ________

Complete if Married

Name of Spouse ______________________________

Work/Cell Phone ____________ / ____________

Employer ______________________________

Address ______________________________

City ________________ State ____ Zip ________

Family Doctor ______________________________

Referring Physician ______________________________

Address ______________________________

____

Authorization to pay Orthopaedic Consultants

X ______________________________

Acknowledgement of Receipt of Notice of Privacy Practices

I, ______________________________, have received the Notice of Privacy Practices from Orthopaedic Consultants.

X ______________________________ Date ____________

In lieu of patient signature, I, ______________________, a staff member at Orthopaedic Consultants, state that ______________________ has been given our current Notice of Privacy Practices.

X ______________________________ Date ____________

PLEASE COMPLETE AND RETURN