Northeast Surgical Group, P.C.

## Patient & Responsible Party Information...part 1

**Patient's *complete legal* name** _____
***(should match your legal ID = License/Passport)*** LAST FIRST MIDDLE INITIAL JR, SR, ETC

**Date of Birth:** _____/_____/_____ **Sex:** Male Female

***Social Security** #XXX-XX-_____ ***last 4 digits only***

**Email:**

**Home phone** (_____)_____-_____ **Cell phone** (_____)_____-_____
***ONLY LIST IF YOU MONITOR YOUR VOICEMAIL – OR – IF THIS IS YOUR ONLY PHONE

**Address**_____**City**_____ **State**_____ **Zip**_____

**Marital Status** *(Please circle one)* Single Married Divorced Legally Separated Widowed

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**Patient's Employer** _____ Occupation _____

Employment address_____ City_____State_____Zip _____

Phone (_____)_____-_____

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**If retired**, please provide date this occurred:_____

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**If disabled**, please provide date this occurred:_____

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**If you are MARRIED, please provide…** Spouse's complete name:_____

Spouse's employer _____Spouse's Occupation _____

Spouse's phone # at work (_____)_____-_____ Cell phone (_____)_____-_____

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**Please provide an emergency contact person who *does not* live with you:**

Name _____ Relationship _____

Phone number (_____)_____-_____ Alternate number: (_____)_____-_____

**********

**My signature below verifies that the information provided on this document is accurate as of today's date:**

**Patient's PRINTED name**: _____

**ACCOUNT#** _____
***FOR OFFICE USE ONLY***

_____ _____

**SIGNATURE OF**: ***(PLEASE CIRCLE)*** Patient / Parent / Guardian / Patient Advocate **Date**

17375 Hall Road, Macomb, MI 48044 *** Telephone 586-228-0550 ***Fax 586-228-8830

Northeast Surgical Group, P.C.

# Patient & Responsible Party Information...part 2

**▶ Please ☑check the appropriate box(es) and provide complete information as it applies**

❑ **I AM MY OWN GUARDIAN** and do not require or enlist any other party to sign on my behalf in decisions relative to healthcare.

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❑ **THE PATIENT IS UNDER 18 YEARS OF AGE**: **parent / guardian must complete the following, provide legal identification, and accompany the patient to all appointments:**

Mother's Name (first & last):_____ Date of Birth:_____
Mother's Employer _____ Phone # at work (_____)_____-_____
Father's Name (first & last):_____ Date of Birth:_____
Father's Employer _____ Phone # at work (_____)_____-_____
Other: _____ Relationship: _____
Phone # at work: (_____)_____-_____ Cell / Alternate Phone (_____)_____-_____

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❑ **THE PATIENT HAS A COURT APPOINTED LEGAL GUARDIAN: A VALID COPY OF THE DOCUMENTATION INDICATING SUCH MUST BE PROVIDED, and THE RESPONSIBLE PARTY INDICATED MUST PROVIDE LEGAL IDENTIFICATION, ACCOMPANY THE PATIENT TO ALL APPOINTMENTS AND SIGN ALL DOCUMENTS RELATIVE TO THE PATIENT'S HEALTHCARE DECISIONS.**

❑ **THE PATIENT HAS A PATIENT ADVOCATE / POWER OF ATTORNEY: A VALID COPY OF THE DOCUMENTATION INDICATING SUCH MUST BE PROVIDED, and THE RESPONSIBLE PARTY INDICATED MUST PROVIDE LEGAL IDENTIFICATION AND ACCOMPANY THE PATIENT TO ALL APPOINTMENTS, UNLESS OTHERWISE NOTED IN THE DOCUMENTATION.**

Name of Legal Guardian / Power of Attorney:_____
Phone number (_____)_____-_____ Alternate Phone number (_____)_____-_____
Address _____ City_____ State _____ Zip_____

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❑ **THE PATIENT RESIDES IN AN EXTENDED CARE FACILITY / NURSING HOME / ETC.**

Facility Name: _____
Address:_____City_____ State _____ Zip_____
Phone (____)_____-_____**Name of physician on-staff there?**_____

******THIS PHYSICIAN'S INFORMATION MUST BE PROVIDED ON THE CORRESPONDENCE PAGE***

**********

**My signature below verifies that the information provided on this document is accurate as of today's date:**

**Patient's PRINTED name**: _____

**ACCOUNT#** _____
***FOR OFFICE USE ONLY***

_____ _____

**SIGNATURE OF**: ***(PLEASE CIRCLE)*** Patient / Parent / Guardian / Patient Advocate Date

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