

**PATIENT'S INFORMATION**      FSMAC #: \_\_\_\_\_      LA - VENTURA SURGERY CENTER #: \_\_\_\_\_  
(FOR OFFICE USE ONLY)      (FOR OFFICE USE ONLY)

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_ Alternative Phone Number: \_\_\_\_\_ Biological Sex:  M  F  Intersex

Drivers License Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Marital Status:  Single  Married  Divorced

Occupation: \_\_\_\_\_  Widow  Widower  Domestic Partner

Employer: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Do we have permission to leave a message for you or your partner on your home, cell, alt, or work phone number?  Yes  No

Do we have permission to release medical information to your partner?  Yes  No Preferred Pronouns: \_\_\_\_\_

Email Address: \_\_\_\_\_ Gender:  Male  Female  Other \_\_\_\_\_

May we email you or your partner's medical info, updates, and FSAC mailings to the above email address?  Yes  No

Emergency Contact Person: \_\_\_\_\_ Relationship to Pt.: \_\_\_\_\_

Phone number where they can be reached: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

*I certify that the information on this form is true and correct to the best of my knowledge, and that I will notify FSMAC of any changes. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any services rendered.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**PARTNER'S INFORMATION**      FSMAC #: \_\_\_\_\_      LA - VENTURA SURGERY CENTER #: \_\_\_\_\_  
(FOR OFFICE USE ONLY)      (FOR OFFICE USE ONLY)

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_ Alternative Phone Number: \_\_\_\_\_ Biological Sex:  M  F  Intersex

Drivers License Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Marital Status:  Single  Married  Divorced

Occupation: \_\_\_\_\_  Widow  Widower  Domestic Partner

Employer: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Do we have permission to leave a message for you or your partner on your home, cell, alt, or work phone number?  Yes  No

Do we have permission to release medical information to your partner?  Yes  No Preferred Pronouns: \_\_\_\_\_

Email Address: \_\_\_\_\_ Gender:  Male  Female  Other \_\_\_\_\_

May we email you or your partner's medical info, updates, and FSAC mailings to the above email address?  Yes  No

Emergency Contact Person: \_\_\_\_\_ Relationship to Pt.: \_\_\_\_\_

Phone number where they can be reached: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

*I certify that the information on this form is true and correct to the best of my knowledge, and that I will notify FSMAC of any changes. I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any services rendered.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_