PATIENT'S INFORMATION **FSAC #:** _____ (FOR OFFICE USE ONLY) **LA - VENTURA SURGERY CENTER #:** _____ (FOR OFFICE USE ONLY)

First Name: _____ **MI:** _____ **Last:** _____

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

Home Phone Number: _____ **Birth Date:** _____ **Age:** _____

Cell Phone Number: _____ _____ **Biological Sex:** □ **M** □ **F** □ **Intersex**_____

Driver's License Number: _____ **Expiration Date:** _____

Social Security Number: _____ **Marital Status:** □ **Single** □ **Married** □ **Divorced**

Occupation: _____ □ **Widow** □ **Widower** □ **Domestic Partner**

Employer: _____

Email Address: _____ **Gender:** □ **Male** □ **Female** □ **Other**_____

Do we have permission to call, leave a message, email, or text you or your partner on your home, cell, or email? □ **Yes** □ **No**

May we contact you via text or email to provide visit reminders, appointment scheduling, medical and educational information, mailings, or to request a review from you related to your care? □ **Yes** □ **No**

Do we have permission to release medical information to your partner? □ **Yes** □ **No** **Preferred Pronouns:** _____

Emergency Contact: _____ **Emer Phone #:**_____ **Relationship to Pt.:** _____

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 FSAC 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:** _____

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

Driver's License Number: _____ **Expiration Date:** _____

Social Security Number: _____ **Marital Status:** □ **Single** □ **Married** □ **Divorced**

Occupation: _____ □ **Widow** □ **Widower** □ **Domestic Partner**

Employer: _____

Email Address: _____ **Gender:** □ **Male** □ **Female** □ **Other**_____

Do we have permission to call, leave a message, email or text you or your partner on your home, cell, or email? □ **Yes** □ **No**

Do we have permission to release medical information to your partner? □ **Yes** □ **No** **Preferred Pronouns:** _____

Emergency Contact: _____ **Emer Phone #:**_____ **Relationship to Pt.:** _____

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 FSAC 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:** _____