METHODIST

Methodist Physicians Clinic
Council Bluffs Surgical Associates
201 Ridge Street Ste. 214
Council Bluffs, Iowa 51503

Phone: (712) 396-4320 / Fax: (712) 396-4328

PATIENT INTAKE

Patient Name:_____ Marital Status: M S D W
Last First MI Maiden

Address:_____
Street Apt # City State Zip Code

Date of Birth:_____ Age:_____ Sex: M F E-Mail:_____

Soc Sec #:_____ Employer:_____

Phone: Home: _____ Work: _____ Cellular: _____

Preferred Language: _____

Race/Ethnicity: ❒ Asian ❒ Black or African American ❒ Caucasian/White ❒ Hispanic or Latino ❒ Other_____

Primary/Family Physician: _____ Referring Physician: _____

Spouse Information

Spouse Full Name: _____ Date of Birth:_____

SSN#_____ E-Mail: _____ Cellular:_____

Spouse Employer: _____ Work Phone:_____

Parent or Guardian Information If Under 18 Years of Age

Father's Name:_____ Date of Birth:_____

Address:_____ Home Phone:_____
Street Apt # City State Zip Code

Employer:_____ Work Phone:_____

SSN#_____ E-Mail: _____ Cellular:_____

Mother's Name:_____ Date of Birth:_____

Address:_____ Home Phone:_____
Street Apt # City State Zip Code

Employer:_____ Work Phone:_____

SSN#_____ E-Mail: _____ Cellular:_____

Emergency Contact Information

Name:_____ Relationship:_____

Address: _____ Phone:_____

Office Visit Information

Reason for Visit: _____

Date of Symptoms:_____

Seen in ER: ❒ Yes ❒ No Where?_____ When?_____

Pharmacy Information

Pharmacy Preferred: (Name) _____

_____

Pharmacy Location:_____ Phone #:_____

Insurance Information: (copy of insurance card is needed)

Insurance Name:_____ Policy Holder_____
Primary Name Date of Birth

Insurance Name:_____ Policy Holder_____
Primary Name Date of Birth

If patient is a minor, please print name of parent or guardian responsible for bill: _____

Address: _____
Street City State Zip Code

If this is an injury, is the injury related to an on-the-job accident? ■ Yes ■ No (Check one)

If Yes: a) Have you reported the accident to your employer? ❒ Yes ❒ No
b) Were you referred by a Work Comp doctor? ❒ Yes ❒ No
If No: a) Was this a car accident? ❒ Yes ❒ No
b) Did the injury occur on another person's property? ❒ Yes ❒ No

Workmen's Compensation Information

Company Name: _____ Phone:_____

Address:_____
Street Apt # City State Zip Code

Supervisor Name:_____ Date of Injury: _____

Have you missed any work due to the injury?_____ What symptoms:_____

What were you doing at time of injury? _____

Do you have an attorney representing you in the above injury? ❒ Yes ❒ No

If Yes: Attorney Name:_____ Phone #:_____

Address:_____
Street City State Zip Code

Motor Vehicle Accident Information

Date of Accident:_____

Do you have an attorney representing you in the above injury? ❒ Yes ❒ No

If Yes: Attorney Name:_____ Phone #:_____

Address:_____
Street City State Zip Code

HIPAA Release of Information

Please complete the names & phone numbers where we can contact you or leave a message.
(Exception: X-Ray, Path and/or Lab results will be given only to the patient or designated person(s).

Please contact me as follows: (check at least one)

❒ Home/Cell Telephone: (____) _____
❒ Leave message with appointment date & time ❒ Leave message with call back number only ❒ Do not leave message

❒ Work Telephone: (____) _____
❒ Leave message with appointment date & time ❒ Leave message with call back number only ❒ Do not leave message

❒ Written Communication:
❒ Mail to my home address:_____
❒ Mail to my work address:_____

If we are unable to reach you, who, if anyone/or what designated person(s), may we disclose medical and/or billing information?

❒ Spouse:_____ ❒ Fiancé: _____
❒ Parent(s):_____ ❒ Adult Children: _____
❒ Sibling(s): _____ ❒ Other Relative/Friend_____

_____ _____ _____
(Patient /Patient Representative Signature) (Relationship to Patient) Date