SURGICAL HOSPITAL OF OKLAHOMA **100 SE 59TH St. Oklahoma City, OK 73129**

Is your injury related to an accident? **Yes** **No**

If yes, what type of accident? Workers Comp **Yes** **No** Motor Vehicle **Yes** **No** Other **Yes** **No**

PATIENT INFORMATION:

Name: _____ Address: _____
(Last) (First) (Middle)

City: _____State: _____County: _____Zip: _____

Home Phone: (____)_____ Cell Phone: (____)_____ Date of Birth: _____

Social Security #: _____Gender: _____Marital Status: _____ Race: _____Religion: _____

PATIENT EMPLOYER INFORMATION:

Name: _____ Phone #:(_____)_____

Address: _____City: _____ State: _____Zip: _____

SPOUSE INFORMATION:

Name: _____Address: _____City: _____State: _____ Zip: _____

Date of Birth: _____ Social Security #: _____

PARENT INFORMATION: (IF MINOR)

Father Name: _____ Date of Birth: _____ Social Security #: _____

Mother Name: _____ Date of Birth: _____ Social Security #: _____

GUARANTOR INFORMATION (Financially Responsible)

Name: _____ Address: _____
(Last) (First) (Middle)

City: _____State: _____County: _____Zip: _____

Home Phone: (____)_____ Date of Birth: _____ Social Security #: _____

GUARANTOR EMPLOYER INFORMATION:

Name: _____ Phone #:(_____)_____

Address: _____City: _____State: _____Zip: _____

PATIENT STICKER

PLEASE COMPLETE BACK SIDE OF FORM

INSURANCE INFORMATION:
PRIMARY INSURANCE COMPANY

Insurance Name:_____Address:_____

City: _____State: _____Zip: _____Phone: _____ Contact: _____

Subscriber Name: _____ Address: _____City: _____

State: _____Zip: _____Employer:_____Address:_____

Relation: _____Gender: F M Date of Birth: _____Id Number:_____

Group Name/Number: _____Claim Number: _____Date of Injury: _____

SECONDARY INSURANCE COMPANY

Insurance Name: _____Address: _____

City: _____State: _____Zip: _____Phone: _____ Contact: _____

Subscriber Name: _____ Address: _____City: _____

State: _____Zip: _____Employer: _____Address: _____

Relation: _____Gender: F M Date of Birth: _____Id Number: _____

Group Name/Number: _____Claim Number: _____Date of Injury: _____

TERTIARY (THIRD) INSURANCE COMPANY or LEGAL COUNSEL

Name: _____Address: _____

City: _____State: _____Zip: _____Phone: _____ Contact: _____

Subscriber Name: _____ Address: _____City: _____

State: _____Zip: _____Employer: _____Address: _____

Relation: _____Gender: F M Date of Birth: _____Id Number: _____

Group Name/Number: _____Claim Number: _____Date of Injury: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby assign payment directly to the Surgical Hospital of Oklahoma (SHO) all Surgical and/or Medical Benefits otherwise payable to me for SHO's services. Any unpaid deductible and/or co-pay are due and payable the day of surgery. I understand that charges may not be payable by insurance are my responsibility and all charges are due in full within 90 days from the date of surgery.

I also authorize SHO to release any information acquired in the course of examination to treatment to my insurance company.

Signed: _____Date: _____