

Patient Demographics Sheet

Have you been treated by an LSA surgeon before?: ☐ Yes ☐ No If yes, contact office ASAP before appt.

CURRENT SURGEONS:
(Check all that apply.)

- | | |
|--|--|
| <input type="checkbox"/> Douglas B. Aach, MD, FACS | <input type="checkbox"/> Deirdre M. Hart, MD, FACS, FASCRS |
| <input type="checkbox"/> T. Vinh Luong, MD, FACS | <input type="checkbox"/> Paul E. Loethen, MD, FACS |
| <input type="checkbox"/> Kevin T. Barnett, MD, FACS | <input type="checkbox"/> Matthew R. Smith, DO |
| <input type="checkbox"/> Michael A. Bergom, MD, FACS | <input type="checkbox"/> Lyman "Lance" Hale IV, MD, FACS |
| <input type="checkbox"/> D. Scott Crouch, MD, FACS | <input type="checkbox"/> Scott Schwiesow, MD, FACS |
| <input type="checkbox"/> Bernard J. Szopa, MD, FACS | <input type="checkbox"/> Ulunna K. MacBean, MD, FACS |

PAST SURGEONS:
(Check all that apply.)

- ☐ James J. Clanahan, MD, FACS

Is this a work-related injury?: ☐ Yes ☐ No

PERSONAL INFORMATION:

Name: _____ DOB: _____
Last First Middle Initial Month Day Year

Address: _____ SSN: _____

City State Zip Code Sex: ☐ Male ☐ Female

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ Marital Status: ☐ Single ☐ Widowed

Preferred Phone (Please check one.) ☐ Married ☐ Divorced

☐ Home ☐ Work ☐ Mobile Email: _____

Employer: _____

Emergency Contact Name: _____ Emergency Contact Relationship

Emergency Contact Phone: _____ to Patient: _____

Spouse, if different from emergency contact: _____

Spouse Phone: _____

Medical Doctor: _____ Referred By: _____

Do you see a specialist (cardiologist, pulmonologist)?: ☐ Yes ☐ No If yes, please list names in field below:

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Patient Name: _____ DOB: ____/____/____ Date: ____/____/____

Pharmacy Name: _____ Pharmacy Number: _____

INSURANCE INFORMATION:

Subscriber's Name: _____ Subscriber's DOB: ____/____/____

Subscriber's Relationship to Patient: _____

Race:

- ☐ Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Black/African-American
- ☐ White/Caucasian
- ☐ More than one race
- ☐ Unreported/refused to report

Ethnicity:

- ☐ Hispanic/Latino
- ☐ Non Hispanic/Latino
- ☐ Unreported/refused to report

Language:

(Check all that apply.)

- ☐ English
- ☐ Spanish
- ☐ French
- ☐ Other: _____



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618.277.7422 **Fax**

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Patient Name: _____ DOB: ____/____/____ Date: ____/____/____

ADDITIONAL NOTES: Write any notable information not included in the form.