

## 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"/> D. Scott Crouch, MD, FACS  |
| <input type="checkbox"/> James J. Clanahan, MD, FACS  | <input type="checkbox"/> Bernard J. Szopa, MD, FACS |
| <input type="checkbox"/> T. Vinh Luong, MD, FACS      | <input type="checkbox"/> Deirdre M. Hart, MD        |
| <input type="checkbox"/> Stacy L. Stratmann, MD, FACS | <input type="checkbox"/> Paul E. Loethen, MD, FACS  |
| <input type="checkbox"/> Kevin T. Barnett, MD, FACS   |   |

**PAST SURGEONS:**  
(Check all that apply.)

- |   |  |
|---|--|
| <input type="checkbox"/> Jay W. Haines II, MD, FACS     | <input type="checkbox"/> Craig R. Smith, MD, FACS        |
| <input type="checkbox"/> Terence P. Wade, MD, FACS      | <input type="checkbox"/> Stephen Striegel, MD, FACS      |
| <input type="checkbox"/> Vidya Shankaran, MD            | <input type="checkbox"/> Bruce D. Jones, DO, FACS        |
| <input type="checkbox"/> William R. Casperson, MD, FACS | <input type="checkbox"/> Briana Waldeck, NP              |
| <input type="checkbox"/> Nathan L. Compton, MD          | <input type="checkbox"/> Elizabeth A. Renaker-Jansen, DO |

Is this a work-related injury?:  Yes  No

**PERSONAL INFORMATION:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First Middle Initial Month Day Year

Address: \_\_\_\_\_ SSN: \_\_\_\_\_  
Street Address

\_\_\_\_\_ Sex:  Male  Female  
City State Zip Code

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Marital Status:  Single  Married

Preferred Phone (Please check one.)  Home  Work  Mobile  Widowed  Divorced

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:



1414 Cross Street, Suite 330  
Shiloh, IL 62269  
618.277.7400 **Phone**  
618.277.7422 **Fax**

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Pharmacy Name: \_\_\_\_\_ Pharmacy Number: \_\_\_\_\_

### INSURANCE INFORMATION:

Subscriber's Name: \_\_\_\_\_ Subscriber's DOB: \_\_\_/\_\_\_/\_\_\_  
Month Day Year

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