

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"/> Vidya Shankaran, MD |
| <input type="checkbox"/> Stacy L. Stratmann, MD, FACS | <input type="checkbox"/> Bruce D. Jones, DO, FACS |
| <input type="checkbox"/> Kevin T. Barnett, MD, FACS | <input type="checkbox"/> Briana Waldeck, NP |
| <input type="checkbox"/> Elizabeth A. Renaker-Jansen, DO | |

PAST SURGEONS:
(Check all that apply.)

- | | |
|---|---|
| <input type="checkbox"/> Jay W. Haines II, MD, FACS | <input type="checkbox"/> William R. Casperson, MD, FACS |
| <input type="checkbox"/> Terence P. Wade, MD, FACS | <input type="checkbox"/> Nathan L. Compton, MD |
| | <input type="checkbox"/> Craig R. Smith, MD, FACS |
| | <input type="checkbox"/> Stephen Striegel, MD, FACS |

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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Patient Name: _____ DOB: ___/___/___ Date: ___/___/___

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.