

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, FACS |
| <input type="checkbox"/> Kevin T. Barnett, MD, FACS | <input type="checkbox"/> Paul E. Loethen, MD, FACS |
| <input type="checkbox"/> Michael A. Bergom, MD, FACS | <input type="checkbox"/> Wade D. Kubat, DO, FACOS |
| | <input type="checkbox"/> Matthew R. Smith, DO |

PAST SURGEONS:
(Check all that apply.)

- | | |
|---|--|
| <input type="checkbox"/> Jay W. Haines II, 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"/> Nathan L. Compton, MD | <input type="checkbox"/> Elizabeth A. Renaker-Jansen, DO |
| <input type="checkbox"/> Craig R. Smith, MD, FACS | <input type="checkbox"/> Stacy L. Stratmann, 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:

Patient Demographics Sheet

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: _____



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

Patient Demographics Sheet

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

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