Treasure Coast
Surgical Center, Inc.
1811 S. 25th Street • Fort Pierce, FL 34947
(772) 467-1960

Primary Physician: _____
(Out of area doctors please write address or phone number)

Patient Name: _____ Age: _____ Sex: M / F
Circle:

Race (required by State law): ❒ American Indian/or Alaska Native ❒ Asian ❒ Black/or African American
❒ Native Hawaiian or Pacific Islander ❒ White ❒ Other ❒ Unknown

Ethnicity (required by State law): ❒ Hispanic or Latino ❒ Non-Hispanic or Latino ❒ Unknown

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Email: _____ Pharmacy: _____

Marital Status: ❒ Married ❒ Single ❒ Divorced ❒ Widow ❒ Widower

Date of Birth: _____ Social Security #: _____

Employer: _____

Spouse's Name: _____ DOB: _____ Social Security #: _____

Spouse's Employer: _____ Phone: _____

Responsible Adult Companion (RAC) (must accompany you to Center): _____

Are you allergic to latex?_____ (Does not include adhesive, elastic, rubber, etc.)

If YES, PLEASE INFORM THE CENTER STAFF IMMEDIATELY.

Medication or Chemical Allergies: _____

List of Current Medication and Dosage (please fill out current medication and dosage as well as vitamins and over-the-counter medication on Page 3).

Do you pre-medicate with antibiotics for procedures? _____ YES _____ NO

Blood thinners or Aspirin products you now take: _____

List any medical conditions you have: _____

Prosthesis replacement if any: _____

Female patient: Pregnant _____ YES _____ NO

Assignment of Benefits and Release of Information:

I authorize the payment of medical benefits to Treasure Coast Surgical Center, Inc., Gulfstream Anesthesia and Tesoro Lab. I authorize the transfer of funds between all listed entities. I request payment of government benefits either to myself or to the party who accepts assignment. I also authorize the release of any medical information necessary to process my claim. I understand I am responsible for the deductible or co-payment.

Signature _____ **Date** _____

PATIENT LABEL