SURGICAL GUEST INFORMATION SHEET

Patient Name: _____
Last First M.I.
Local Address: _____

City/State: _____Zip: _____
Are you a permanent Florida Resident: [ ] Yes [ ] No
If no, please list northern address & phone: _____
_____

Social Security # _____ Local Home Phone: _____
Sex: [ ] Male [ ] Female Birth date: _____ Marital Status: _____
Spouse's Birth date _____ Social Security #: _____(If Applicable)

Local Family Doctor or Internist: _____ Referred By: _____

Are you employed: [ ] Yes [ ] No If Yes, Employer Name: _____
Address: _____
_____
**Please bring your current insurance cards with you to your surgery appointment.

Do you have an Advance Directive **[ ] Yes [ ] No**
If you answered ***Yes*** to the Advance Directive, you must bring a photocopy to St. Barbara's Surgery Center to become part of your surgical chart/medical records.
If you answered ***No*** to the Advance Directive, and would like to obtain more information please visit www.uslivingwillregistry.com/forms/shtm or ask our receptionist for information about Advance Directives.

St. Barbara's Surgery Center Policy on Advance Directive: In the ambulatory care setting, if a patient should suffer cardiac or respiratory arrest or other life threatening situation, the signed informed consent implies consent for resuscitation and transfer to a higher level of care. Therefore, in accordance with federal and state law, the facility is notifying you it will not honor previously signed advance directives for any patient. If you disagree, you must address this issue with your surgeon or anesthetist prior to the scheduled date of surgery. **Your signature on this form means you understand and agree that any advance directive regarding your medical care will not be honored at St. Barbara's Surgery Center.**

Signature: _____ Date: _____