Advanced Surgical Care
Dr. Ted Kovacev
Surgery

11/22/2016

Patient Registration

Last Name: _____ First Name: _____ MI: _____

Mailing Address: _____

City: _____ State: TX ☐ , Other _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Age: _____ Date of Birth: _____ Sex: M☐ F☐

Social Security #: _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other ☐ _____

Spouse's Name: _____

Do you consent to receive statements and appointments by email: Yes☐ No☐

Email Address: _____

Preferred Pharmacy: _____ Location: _____

Do you have a primary care doctor? Yes☐ No☐ Name: _____

Employment Information

Employment Status: Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☐ Self-Employed ☐ Student ☐

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____ Extension: _____

Payment Information

Do you have insurance? Yes ☐ No ☐ Are you a self-pay patient? Yes ☐ No ☐

How did you find Dr. Kovacev? _____

Person to notify in case of emergency: _____Relationship:_____

Phone: _____ Cell ☐ Home ☐ Other ☐

Primary Insurance Holder (if different from above)

Name : _____ Relationship to patient: _____

Social Security # _____ Date of Birth: _____

Mailing Address: _____ City: _____

State: _____ Zip:_____ Cell Phone: _____