BAYONET POINT SURGERY & ENDOSCOPY CENTER

14104 Yosemite Drive
Hudson, FL 34667
Office (727) 869-5040 ♦ Fax (727) 869-5041

Name____Home #____________________________

Address____Sex (circle) M F

City/State/Zip____

Social Security #_______________Birth Date_________Email (optional)_____________________

Place of Employment____

Address____

City/State/Zip____

Position Held____

Marital Status_______________________Spouse/Parent's Name____________________________

Medical Doctor's Name_________________________________Phone #______________________

Name of Nearest Relative or Friend (locally) **NOT LIVING WITH YOU**______________________

Phone #__________________________________Relationship to you________________________

To our patients:
State regulations require us to collect the following racial information for statistical purposes. Please choose a selection from the choices below. (If you do not wish to disclose this information please select "No Response").

______Asian ______African American ______Hispanic Non-Caucasian ______Hispanic

______Caucasian ______Native American ______Other ______No Response

Medicare Secondary Payor Screening

1. Are you currently receiving Medicare Benefits? **YES** **NO** (if "YES", please answer questions 2,3, & 4)
2. Are either you or your spouse currently working? **YES** **NO**
3. Are either you or your spouse currently provided with any group health coverage? **YES** **NO**
4. Are you currently receiving any other health care benefits (i.e. Black Lung, Veterans Affairs, Government research program grant, work, non-work or automobile related injury or illness benefits)? **YES** **NO**

Advanced Directives

1. **YES, I DO** **NO I DO NOT** have an Advanced Directive, Living Will, or Health Care Power of Attorney.
   (If YES, then another form will be provided for your review and acknowledgement.)
2. **Yes, I DO** **NO I DO NOT** want to have information on Advanced Directives.
   (If YES, then a brochure will be made available to you for your review.)

I have reviewed and agree with the above.

______________________________________ ______________________
SIGNATURE OF RESPONSIBLE PARTY **DATE**

______________________________________ ______________________
WITNESS **DATE**