**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**