

## 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. John'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](http://www.uslivingwillregistry.com/forms/shtm) or ask our receptionist for information about Advance Directives.

**St. John'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 anesthesiologist 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. John's Surgery Center.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_