**TOSC Registration Form**

We want to make sure that you understand every part of your care today. If you are able to read and understand this message please circle and initial Yes Initials_____

Please acknowledge that you have received the list of physician ownership of Tallahassee Outpatient Surgery Center (prior to your procedure) with your initials._____

**Patient Name**_____
**Last First Middle Initial**

**Address:**_____
**Street City State Zip Code**

**Home Phone:**_____-_____ **Work Phone:**_____-_____ **Cell Phone:**_____-_____

**email address** _____

**Date of Birth:**_____ **Age:**_____ **Sex: M / F** **Social Security #** _____

**Marital Status:** **Married / Single / Divorced / Legally Separated / Widowed**

**Race (required by state):** **White / Black / Hispanic / Asian / American Indian / Other**_____

**Employment Status:** **Employed / Retired / Full-Time Student / Minor**

**Employer Name:**_____

**If Full Time Student:**_____
**Name of School Phone No**

**Emergency Contact Person:**_____

**Relationship to Patient:**_____ **Phone No:**_____-_____

**Date of Injury:** _____
**Month Day Year**

**Are you having a procedure done due to an accident type listed below?: Y / N**
**-If yes, was the accident: Work Related / School Related / Automobile Related (Please circle one.)**
**Name & address of location of accident or name of auto company covering injury:**

_____

**IF PATIENT IS A MINOR/DEPENDENT COMPLETE THE FOLLOWING:**

**Parent/Guardian Name (please specify):** _____

**Address**_____ **Phone No:** _____-_____

**Date of Birth** _____ **Social Security Number**_____

**Guardians must have court documents designating them as the legal guardian in order to sign the consent, and on day of surgery.**