



160 Robbins Street • Waterbury, CT 06708 • (203) 755-6663

### PATIENT DATA FORM

Have you ever been here before? \_\_\_\_\_ When \_\_\_\_\_  
Was your name the same? **YES NO**, If no, Your Name was \_\_\_\_\_

Date of Surgery \_\_\_\_\_  
Account Number \_\_\_\_\_

#### PATIENT INFORMATION; (PLEASE PRINT)

Last Name		First		Middle Initial	Surgeon
Street Address			City		State Zip Code
Birthdate (D.O.B.) MO. DAY YR	Age	Sex M ___ F ___	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> SEP	S.S. #	Phone: Home _____ Bus _____ Cell _____
Occupation: (If student) Name of school	Employer	Employer Full Address			Relationship
Name & Address of nearest relative not living with you?				Phone	Relationship

#### IN CASE OF EMERGENCY:

Name	Address	Phone	Relationship
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#### INSURANCE COVERAGE: Group Health insurance with employer? Yes NO

Primary Insurance Company	Policyholder	D.O.B.	SS#
Insurance Address:	Group Name & Number	Policy Number	
Secondary Insurance Company	Policyholder	D.O.B.	SS#
Insurance Address:	Group Name & Number	Policy Number	
Third Insurance Company	Policyholder	D.O.B.	SS#
Insurance Address:	Group Name & Number	Policy Number	

<b>WELFARE:</b> (Case No. if applicable)	Case Name:	Supervisor Relative If AFDC	Date of Eligibility
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#### ACCIDENT/WORKERS COMPENSATION INFORMATION: (Complete only if admission is result of an accident)

TYPE OF INJURY Auto Occupational Home Other	Date of Injury	Time of Injury	Where Injury Occurred	Claim Number
(Please fill out if this is a workers compensation claim)				
Employer at time of injury	Employer Address	Employer Phone	Contact Name	
Workers Compensation Carrier	Carrier Address	Mail Claim to: <input type="checkbox"/> Employer <input type="checkbox"/> Carrier		

#### FINANCIAL RESPONSIBILITY: (Person assuming financial responsibility for this account)

Last Name	First	Middle Initial	Phone #	Relationship to Patient
Street Address		City and State		Social Security No.
Place of Employment	Address	Occupation	How Long	

I certify that the information given is correct.

Signature of patient or guardian

Date

# NAUGATUCK VALLEY SURGICAL CENTER OWNERSHIP DISCLOSURE

In compliance with the Medicare Conditions for Coverage, the ownership of this facility is hereby disclosed:

The Naugatuck Valley Surgical Center is a Limited Partnership, whose General partner is St. Mary's Hospital

And whose Limited Partners are listed below:

Dr. Charles Arena  
Dr., Yjing-Sek and Mrs. Helen Chan  
Dr. Mark Eisenberg  
Dr. Stanley B. Hersh  
Dr. Robert & Mrs. Ruth Lesser  
Dr. Richard Matza (through BMR Trust)  
Dr. Michael Karnasiewicz (through Rebel Oaks, LLC)  
Dr. Martin J. Spinella  
Dr. Andrew Nelson (through Allen Reality, LLC)  
Dr. Michael Kaplan  
Dr. Bhavesh R. Patel  
Dr. Prasad Sureddi (through Sureddi Family LTD Partnership, LLC)  
Dr. Peter Branden  
Dr. Craig Sklar  
Dr. Stephanie I. Sigin  
Dr. Andrew Levada  
Dr. Yania Kostina-O'Neil  
Dr. Jonathan Silbert  
St. Mary's Hospital