

Patient Registration

Account #: _____

Patient Information:

Name (Last, First, Middle): _____

Sex _____ Race _____ Birth date _____ Age _____

Address _____ City, State, Zip _____

Home Phone _____ Work Phone _____

Social Security Number _____ Marital Status _____

Guarantor (Name: Last, First, Middle): _____

Address _____ City, State, Zip _____

Home Phone _____ Work Phone _____

Primary Insurance

Insurer _____ Insured's Name _____

Address _____ City, State, Zip _____

Patient's Relation to the Insured _____ Insured's ID No. _____ Group Name _____ Group No. _____

Insured's Employer _____ Insured's Employer Address _____

Authorization No. _____

Secondary Insurance

Insurer	Insured's Name		
Address			City, State, Zip
Patient's Relation to the Insured	Insured's ID No.	Group Name	Group No.
Insured's Employer	Insured's Employer Address		
Authorization No.			

Surgery Information

Date of Surgery	Time of Surgery	Date of Pre-Test	Time of Pre-Test
Surgeon Name and No.		Type of Anesthesia	
Primary Diagnosis (Code)			
Primary Procedure		Secondary Procedure	
L R B		L R B	

I hereby assign payment directly to the surgery center all surgical and/or Medical Benefits otherwise payable to me for its services but not to exceed its charges. Any unpaid deductible and/or estimated co-pay is due and payable the day of surgery. I understand that charges not payable by insurance is my responsibility and all charges are due in full within 90 days from the date of surgery regardless of any insurance pending.

I also authorize the surgery center to release information (to include information regarding communicable or venereal diseases) acquired in the course of examination or treatment to my insurance company, peer review or hospital if transferred for follow-up care.

I understand that I will receive sedation or anesthesia for my surgery. The following adult will assume responsibility for me after my surgery.

Name: _____ Phone: _____

Patient Signature: _____ Date: _____