

# 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 \_\_\_\_\_

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**Guarantor** (Name: Last, First, Middle): \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

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**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: \_\_\_\_\_