PATIENT REGISTRATION

Patient Information: Race | Birth date | Age | Sex | Account Number

Address | City, State, Zip code

Home Phone | Work Phone | Marital Status | SSN

Cell Phone

Primary Insurance: | Insured's Name | Date of Birth

Address | City, State, Zip code | Phone Number

Patient's Relation to the Insured | Insured's ID Number | DOI

Group Name | Group Number | W/C Number | Authorization #

Insured Employer | Insured's Employer Address

Secondary Insurance: | Insured's Name | Date of Birth

Address | City, State, Zip code | Phone Number

Patient's Relation to the Insured | Insured's ID Number

Group Name | Group Number | Authorization #

Insured Employer | Insured's Employer Address

Emergency Contact: | Phone Number | Patient Email Address

Surgery Information:

Date of Surgery | Time of Surgery | Type of Anesthesia

Physician | Refering

Planned Procedures | Pre-Op Diagnoses

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private and group insurance, or other health plan to the Surgery Center.

RELEASE OF INFORMATION: A photocopy of this assignment is to be considered valid as an original and revocable by me only in writing. hereby authorize said assignees to release all information to secure payment.

FINANCIAL RESPONSIBILITY: I accept ultimate financial responsibility for accounts with the Surgery Center whether paid by insurance or not.

ADVANCE DIRECTIVE:

☐ I have executed an Advanced Directive. A copy has been supplied to the center. ☐ Yes ☐ No

☐ I have not executed an Advance Directive

ACKNOWLEDGEMENT OF RECEIPT

☐ I have received a copy of the Patient Guide prior to my arrival to the center.

☐ I have received a copy of the Notice of Privacy Practices and the Patient Rights and Responsibilities.

☐ I do not wish for any information regarding my Personal Health or Medical records to be shared.

☐ For this visit, I allow for my Personal Health Information or Medical records to be shared with:

I acknowledge that the information stated above is correct to the best of my knowledge.

Patient Signature or Personal Representative ID Checked

_____ ☐ Signed

If Personal Representative's signature appears above, please document relationship to patient: