

PATIENT REGISTRATION FORM

Today's Date: _____

Specialists in General Surgery, Ltd.

Acct #: _____

Referred By: _____

Primary Care (Family) Physician

Clinic Name/Location: _____

PATIENT

Male

Female

Single

Marital

Married

Divorced

Spouse's

Name: _____
Last First Middle

Status Separated Widowed Name: _____

Address: _____
Street City Zip

Home Phone: (_____) _____ Work Phone: (_____) _____ Birthdate: _____ Age: _____

Cell Phone: (_____) _____ Pager: (_____) _____ E-Mail Address: _____

Employer: _____ Social Security #: _____

Who may we discuss your care with/phone#: _____

Notify in Case of Emergency

EMERGENCY

Name: _____ Relationship: _____ Phone: _____
Last First Middle

Address: _____
Street City State Zip

INSURANCE INFORMATION/RESPONSIBLE PARTY

Please provide insurance

Card for us to copy

PRIMARY

SECONDARY

Insurance Company: _____

Insurance Company: _____

Policyholder Name: _____

Policyholder Name: _____

Policyholder Date of Birth: _____

Policyholder Date of Birth: _____

Policyholder S.S. #: _____

Policyholder S.S. #: _____

Relationship: _____

Relationship: _____

Certificate or Policy #: _____

Certificate or Policy #: _____

Group #: _____ Effective Date: _____

Group #: _____ Effective Date: _____

Workers Comp

Auto Accident

INSURANCE ASSIGNMENT AND AUTHORIZATION

RECORDS RELEASE: I hereby authorize the release of any information, including medical and billing information to my insurance company, and other providers involved in my care. Our practice may use and disclose your protected health information for research purposes in certain circumstances unless refusal to do so is provided in writing.

ASSIGNMENT OF BENEFITS: I hereby authorize payment of medical benefits to *Specialists in General Surgery* for services rendered to myself and/or dependents.

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made to me or on my behalf to *Specialists in General Surgery* for any services furnished me by that physician/clinic/supervisor. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Signed X _____ **Date:** _____