Surgical Associates, P.C.

Patient Registration Form
Please Print

Patient Information:

Patient Name____
(First) (M.I.) (Last)

Address____
(No. /Street) (City) (State) (Zip)

Home Phone ( ) ______________________ Email address: ______________________

Age__________ Birthdate__________ Sex: M F Marital Status M S D W Soc. Sec. #______________

Patient Employer__________________Address__________________Phone ( ) ____________

Billing Information: (if different from above)

Name____
(First) (M.I.) (Last)

Address____
(No./Street) (City) (State) (Zip)

Home Phone ( ) ______________________ Work Phone ( ) ______________________

Employer______________________ Address______________________

Insurance Information:

Primary Insurance Company____
Group No.______________________ Policy No.______________________
Name of Insured______________________ Relationship to Patient______________________
Secondary Insurance Company____
Group No.______________________ Policy No.______________________
Name of Insured______________________ Relationship to Patient______________________

Worker's Compensation:

Workers Comp Ins. Co.____

Address____
(No./Street) (City) (State) (Zip)

Accident Claim No.______________ Date of Injury______________Date Last Worked______________

Claims Adjuster: ______________________ Phone #( ) ______________________

Employer's Name______________________ Employers Phone # ( ) ______________________

ASSIGNMENT AND RELEASE: I HEARBY AUTHORIZE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN, AND I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. I ALSO AUTHORIZE THE PHYSICIAN TO RELEASE INFORMATION REQUIRED.

SIGNED________________________________DATE______________________