DENNIS W. MAIER, M.D., F.A.C.S.
GEORGE K. BENTZEL, M.D., F.A.C.S.
JEFFREY J. RENTZ, M.D., F.A.C.S.
MICHAEL G. WILCOX, M.D., F.A.C.S.

SURGICAL ASSOCIATES PC
2900 12th Ave North, Suite 355W, Billings, MT 59101
(P) 406-238-6470 / (F) 406-238-6499
www.billingssurgeons.org

ERIC R. DRINGMAN, M.D., F.A.C.S.
KATHRYN F. HATCH, M.D., F.A.C.S.
BARRY A. McKENZIE, M.D., F.A.C.S.
RACHEL L. OTT, M.D.

# PATIENT REGISTRATION

**Patient Information:**

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

Mailing Address____________________________________________
(Street) (City) (State) (Zip)

Home Phone(     )________________Cell Phone(     )________________Email______________________

Birthdate:______________ Sex(circle one): M F T Marital Status(circle one): M S D W P SSN:______________

Employer____________________Address________________________Work Phone(     )______________

Primary Care Provider__________________________Referring Provider__________________________

Emergency Contact______________________ Phone(     )______________ Relationship________________

**Responsible Party/Billing Information**: (complete only if different from above)

Name____________________________________________
(First) (M.I.) (Last)

Mailing Address____________________________________________
(Street) (City) (State) (Zip)

Home Phone(     )________________Cell Phone(     )________________Birthdate:________________

Employer____________________Address________________________Work Phone(     )______________

**Insurance Information:** (bring cards to appointment)

Primary Insurance__________________Policy#____________________Group#______________________

Name of Insured__________________________ Relationship to Patient________________DOB__________

Secondary Insurance________________Policy#____________________Group#______________________

Name of Insured__________________________ Relationship to Patient________________DOB__________

**Worker's Compensation:**

WC Company____________________________Employer____________________Phone(     )__________

Mailing Address____________________________________________
(Street) (City) (State) (Zip)

Accident Claim#__________________ Date of Injury______________ Date Last Worked________________

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.

Patient/Responsible Party Signature:________________________________________Date:______________