

**DEPARTMENT OF SURGERY
Registration Form**

FOR OFFICE USE ONLY	
MRN: _____	Div: _____

Appointment w/:	Today's Date:
-----------------	---------------

Patient Information:

Last Name		First Name		M
Date of Birth	Age	Sex	Marital Status	
Street Address		City/State		Zip Code
Home Phone # ()	Mobile # ()	Work# ()	Email	
Mother's First Name:			Father's First Name:	

This is for medical record purposes only.

Employer Information:

Occupation	Employer's Name/Address
------------	-------------------------

Emergency Contact Information:

Name	Relationship	Phone # () -
------	--------------	---------------

Referral Source (From whom/how did you hear about this Provider?):

Name/Type	Address	Phone # () -
Primary Care Physician	Address	Phone# () -
Physician (Other) _____	Address	Phone # () -

Insurance Information:

Patient Relationship to Guarantor (circle one)	SELF	SPOUSE	DEPENDENT CHILD	STUDENT
Primary Insurance			Policy #	
Guarantor Name			DOB	
Secondary Insurance			Policy #	
Guarantor Name			DOB	

Pharmacy Information:

Circle One:	Retail Pharmacy	Mail-Order Pharmacy	Name
Address			Phone # () -

Financial Responsibility and Release of Information (For Provider Indicated in the "Appointment w/" section of this form)

Medicare Patients: I request that payment of authorized health insurance benefits be made to me or on behalf to the provider(s) for any services furnished to me by this provider. I authorize any holder of 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.

Commercial/Other Insurance: I verify the accuracy of the information on this form. I hereby authorize direct payment of surgical/medical benefits to my provider, for services rendered by him/her in person or under his/her supervision if I have not paid in advance. I understand that I am financially responsibly for all services. Additionally, I understand that all bills are my responsibility if not paid by the carrier. I hereby authorize my provider, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

Out of Network: I understand that the doctor is a **non-participating provider** of my insurance and therefore I will be responsible for any balances on this account.

Self-Pay: I agree to pay at the time the services are rendered.

I verify the accuracy of the above information and authorize the release of information as indicated on this form.	Patient (Guardian) Signature X	Date
I understand and agree to terms of my financial responsibility as indicated on this form.	Patient (Guardian) Signature X	Date