# PATIENT REGISTRATION SHEET

Patient Last Name ______ First ______ Middle ______

Address ______ City ______ State ______ Zip Code ______

M F
Sex ______ Social Security Number ______ Date of Birth ______

(______)______ (______)______
Home Phone ______ Work Phone ______ Employer Name ______

(______)______
Cell Phone ______ Pager or Other Phone Number ______

Insurance Company Name ______ Subscriber's Name *(Whose name is the insurance in?)* ______

Subscriber Date of Birth ______ Subscriber Social Security Number ______

M F self spouse child other
Subscriber Sex ______ Patient Relationship to Subscriber (The patient is the subscriber's........)

______ (______)______
Subscriber's Employer ______ Employer Phone Number ______

______ (______)______
Spouse or Parent Name ______ Relationship to Patient ______ Phone Number ______

______ (______)______
Emergency Contact Name (Other than listed above) ______ Relationship to Patient ______ Phone Number ______

I hereby assign payment directly to the surgery center all surgical and or medical benefits otherwise payable to me for its services but not to exceed its charges. Any unpaid deductible and or estimated co-pay is due and payable the day of the surgery. I understand that charges not payable by insurance is my responsibility and all charges are due in full within 90 days from the date of surgery regardless of any insurance pending.

I also authorize the surgery center to release information (to include information regarding communicable or veneral diseases) acquired in the course of examination or treatment to my insurance company, peer review or hospital if transferred for follow up care.

**PATIENT OR AUTHORIZED PERSON SIGNATURE** ______ Date ______

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