SURGICAL ASSOCIATES, P.A.

PATIENT REGISTRATION Date:_____

PATIENT INFORMATION:

_____ ____/____/___ _____ ☐ MALE ☐ FEMALE
First Name Middle Initial Last Name Date of Birth Age Marital Status _____

Race/Ethnicity:_____Language:_____email address:_____

Mailing address: _____Apt #:_____

City: _____ State: _____ Zip Code:_____

Home Phone #_____Cellular Phone #_____Work Phone #_____

Social Security #_____ Employer: _____

Emergency Contact: _____Emergency Phone # _____Relationship _____

If patient is a minor, parent/guardian name: _____

Referring Doctor: _____Family Doctor: _____

GUARANTOR INFORMATION (Person responsible for paying patients bills)

Name: _____ Date of Birth: _____ Age: _____
Relationship of Patient to Guarantor ☐ same ☐ spouse ☐ child
Street: _____Apt#: _____
City: _____ State: _____ Zip Code: _____
Home Phone # _____Social Security # _____
Employer: _____ Work # _____

PRIMARY MEDICAL INSURANCE INFORMATION:

Insurance Company's Name: _____

Group ID # _____ Plan Owner's ID # _____

SECONDARY MEDICAL INSURANCE INFORMATION:

Insurance Company's Name: _____

Group ID # _____ Plan Owner's ID # _____

TERTIARY MEDICAL INSURANCE INFORMATION:

Insurance Company's Name: _____

Group ID # _____ Plan Owner's ID # _____

WORKERS COMPENSATION/MOTOR VEHICLE ACCIDENT

Is this a job-related injury? ☐ Yes ☐ No Motor vehicle claim? ☐ Yes ☐ No Date of incident _____

Insurance Company's Name: _____

Insurance Company's Address: _____Phone # _____

Claim # _____Adjuster's Name: _____Phone # _____

PATIENT AUTHORIZATION (Patients who are minors must have a parent sign)
I authorize my insurance company to make payment directly to Surgical Associates, PA for all medical services provided to me. I authorize release of medical information as requested by my insurance company. I also agree that I will ultimately be responsible for payment of all medical bills owed to Surgical Associates, PA. **NOTE: Unpaid balances referred to collections will incur a 27% collection fee.**

Signature: _____Date:_____