Surgical Clinic Associates, P.A.

Patient Registration Form

(Please Print & Complete in Full)

Date: _____ ***MRN#*** _____

PATIENT INFORMATION

Social Security# _____-_____-_____ Date of Birth: _____ Age: _____ Please Circle: Male or Female

Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Email: _____

Marital Status: (Please Circle) Single Married Widowed Divorced Separated Other

Race: (Please Circle) Black/African American Asian White/Caucasian Hispanic/Latino Native American Other

If Patient is a Child, Lives with: _____

PATIENT EMPLOYER INFORMATION

Company Name: _____ Main Office Phone: (_____) _____ _____

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION (SUBSCRIBER INFORMATION, IF OTHER THAN PATIENT)

Subscriber Name: _____ Social Security#: _____-_____-_____

Date of Birth: _____/_____/_____ (Please Circle): Male or Female Relationship: _____ Phone #:(_____)-_____-_____

Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance Name: _____ ID#: _____

Secondary Insurance Name: _____ ID#: _____

Primary Care Physician: _____ Phone: (_____) _____-_____

Referring Physician: _____ Phone: (_____) _____-_____

In Case of Emergency:

Relative/Friend: _____ Relationship: _____

Primary Contact Number: (_____) _____-_____ Work Number: (_____) _____-_____

Relative/Friend: _____ Relationship: _____

Primary Contact Number: (_____) _____-_____ Work Number: (_____) _____- _____

The above information is true to the best of my knowledge. Professional fees are due at the time services are rendered. These include but are not limited to copays, deductibles, self-pay and all discount plan payments. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for all balances that are not covered by my insurance plan even if not deemed medically necessary. I also authorize Surgical Clinic Associates, P.A. or the insurance company to release any information required to process my claims. I request that payment of authorized Medicare and/or Medicaid benefits be made on my behalf to Surgical Clinic Associates, P.A.

PATIENT SIGNATURE: _____ **DATE:** _____

RESPONSIBLE PARTY: _____ **DATE:** _____