Surgical Clinic Associates, P.A.

Patient Registration Form

(Please Print & Complete in Full)

Date:_____ **MRN#**_____

PATIENT INFORMATION

Social Security #:_____-_____-_____ Email: _____

Last Name: _____First Name: _____MI:_____

Address: _____

City: _____State: _____Zip:_____

Home Phone: (_____) _____Work Phone: (_____) _____Cell Phone: (_____) _____

Date of Birth:_____/_____/_____ Age: _____ Please Circle: Female or Male

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

Race: (Please Circle): African American Asian Caucasian Hispanic Native American Other

If Patient is a Child, Lives with: _____

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#_____

REFERRED BY:

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

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

IN CASE OF EMERGENCY:

Relative/Friend: _____Relationshi:p:_____

Home or Cell Number: (_____) _____-_____ Work Number: (_____) _____-_____

EMPLOYER INFORMATION:

Name: _____Main Office Phone:_(_____)_____

Address:_____City:_____State:_____Zip:_____

The above information is true to the best of my knowledge. Professional fees are due at the time services are rendered. These include but not limited to co-pays, 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. 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 Medigap benefits be made on my behalf to Surgical Clinic Associates, P.A.

PATIENT:_____ DATE:_____

RESPONSIBLE PARTY:_____ DATE:_____