PATIENT REGISTRATION

Patient's Name ______________________ **PT #** ____________ **Date:** ____________

Mr. Mrs. Miss Ms.
NAME (Last, First, MI): ______________________

Home Phone: ______________________ Work Phone: ______________________

Address: ______________________

City: ______________________ State: ____________ Zip: ____________

Sex: M ☐ F ☐ Marital Status: Married ☐ Single ☐ Divorced ☐ Widowed ☐

Social Security Number: ______________________ Date of Birth: ______________________

Patient Employer: ______________________

Address: ______________________

How did you hear about us? ______________________

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Family Physician: ______________________ Phone: ______________________

Patient's Spouse: ______________________ Work Phone: ______________________

Spouse's Employer: ______________________ Address: ______________________

City: ______________________ State: ____________ Zip: ____________

Alternate Contact (other than your home phone):

Name: ______________________ Phone: ______________________

Insurance: List subscriber name if other than the patient:

Medicare Number: ______________________ Primary: Yes ☐ No ☐

Blue Cross/Blue Shield Number ______________________ Group: ______________________

Other Insurance: ______________________ Group: ______________________

Other Insurance: ______________________ Group: ______________________

I authorize any holder of medical information about me to release to my insurance company and its agents any information needed to determine benefits.

I request that payment of authorized insurance/Medicare benefits be made on my behalf to ______________________ and/or Ambulatory Surgery Center for all assigned to me or on my behalf to ______________________ and/or Ambulatory Surgery Center for any services furnished me by that supplier.

Signature ______________________ Date: ____________

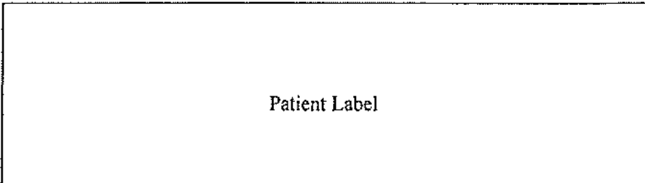
Signature ______________________ Date: ____________

Patient received Privacy Notice and signed acknowledgment Yes ☐ No ☐ Already given ☐

Identification verified by: patient ☐ by picture/gov't issued ID ☐

Consent verified by: patient ☐ by care person ☐ by H & P ☐

Procedure and site identified on consent ☐


Patient Label

BSC-7 (10/08)