THE SURGERY CENTER *of* CENTRALIA

A Community Care Partner

Affix Patient Label Here

PATIENT REGISTRATION

Patient

Name:______________________________ Phone Number: (________) ______________________

Address:______________________________ Birth Date:______________________ Age:__________

City:______________________________ SS#:______________________ Sex: M F

State:__________________ Zip:______________ Marital Status: Single Married Divorced Widowed

County:______________________________ Occupation:______________________________

Employment: Full Time Part Time Not Employed Student Work Phone: (_________) ______________________

Employer:______________________________ Address:______________________________

City:______________________________ State:__________________ Zip:______________

Emergency Contact (Not living in household):______________________________ Phone: (______) ________________

Spouse's Name:______________________________ Phone Number: (________) ______________________

Address:______________________________ Birth Date:______________________ Age:__________

City:______________________________ SS#:______________________ Sex: M F

State:__________________ Zip:______________ County:______________________________

Employment: Full Time Part Time Not Employed Student Occupation:______________________________

Employer:______________________________ Work Phone: (_________) ______________________

Address:______________________________ City:______________________________

______________________________ State:__________________ Zip:______________

If the patient is a minor or insurance is through your mother and/or father, complete this section.

Father's Name:______________________________ Phone Number: (________) ______________________

Address:______________________________ Birth Date:______________________________

City:______________________________ SS#:______________________________

State:__________________ Zip:______________ County:______________________________

Employment: Full Time Part Time Not Employed Student Occupation:______________________________

Employer:______________________________ Work Phone: (_________) ______________________

Address:______________________________ City:______________________________

______________________________ State:__________________ Zip:______________

Mother's Name:______________________________ Phone Number: (________) ______________________

Address:______________________________ Birth Date:______________________________

City:______________________________ SS#:______________________________

State:__________________ Zip:______________ County:______________________________

Employment: Full Time Part Time Not Employed Student Occupation:______________________________

Employer:______________________________ Work Phone: (_________) ______________________

Address:______________________________ City:______________________________

______________________________ State:__________________ Zip:______________

Please Complete Other Side.

Insurance Information

Primary Insurance:____________________________________
Insured's Name:______________________________________
Insured's Date of Birth:_______________________________
Insurance Address:____________________________________
____
City:____
State:_________________________ Zip:________________
Insurance Carrier Phone: (________) ____________________
ID Number:____
Group Number:_______________________________________
Effective Date:_______________________________________

Secondary Insurance:__________________________________
Insured's Name:______________________________________
Insured's Date of Birth:_______________________________
Insurance Address:____________________________________
____
City:____
State:_________________________ Zip:________________
Insurance Carrier Phone: (________) ____________________
ID Number: ____
Group Number:_______________________________________
Effective Date:_______________________________________

Third Insurance:______________________________________
Insured's Name:______________________________________
Insured's Date of Birth:_______________________________
Insurance Address:____________________________________
____
City:____
State:_________________________ Zip:________________
Insurance Carrier Phone: (________) ____________________
ID Number:____
Group Number:_______________________________________
Effective Date:_______________________________________

ASSIGNMENT AND RELEASE

I, the undersigned, agree that I am financially responsible for all charges, whether or not paid by insurance. I hereby assign, directly to the Surgery Center of Centralia, all medical benefits, otherwise payable to me. I also authorize the release of any medical information pertinent to my case to any insurance company, physician, adjuster, attorney or accrediting body involved in this case. A photocopy of this assignment shall be considered as effective and valid as the original.

Responsible Party Signature: **X**____ Date:______________________

I hereby authorize the release of any and all information pertaining to my medical history and/or current diagnosis and treatment, and information pertaining to my insurance coverage and benefits to The Surgery Center of Centralia, its employees, agents and representatives. A photocopy of this authorization shall be considered as effective and valid as the original.

Responsible Party Signature: **X**____ Date:______________________