



PATIENT REGISTRATION

Patient's Name: _____ Date of Birth: _____
Address: _____ SS#: _____
City: _____ State: _____ Zip: _____ Home Phone #: _____
Place of Employment: _____ Work Phone #: _____
Marital Status: [] Single [] Married [] Divorced [] Widowed
Spouse/Parent's Name: _____ Family Physician _____
Who Referred You to Our Office? _____

Primary Insurance Information—Please Complete

Secondary Insurance Information—Please Complete

Ins. Co. Name _____
Group # _____ ID# _____
Policy Holder's Name _____
SS# of Policy Holder _____
Birthdate of Policy Holder _____
Employer _____

Ins. Co. Name _____
Group # _____ ID# _____
Policy Holder's Name _____
SS# of Policy Holder _____
Birthdate of Policy Holder _____
Employer _____

PLEASE COMPLETE THE FOLLOWING: SPOUSE OR PARENT INFORMATION

Name _____ Home Phone # _____
Address _____ Employer _____

If claim will be covered by Worker's Compensation, please complete the following:

If yes, Name of Company _____ Treatment Authorized by _____
Address of Company _____ Phone # _____
Date of Injury _____ Last Day Worked _____

Financial Responsibility/Release of Medical Information Authorization:

I hereby authorize Surgical Associates Southern Indiana to release medical information to my insurance company necessary to process my medical claims. Also, I authorize payment by my insurance company directly to Surgical Associates Southern Indiana any benefits otherwise payable to me but not to exceed stated charges. I understand I am financially responsible for charges not covered by the authorization.

Signature of Patient/Parent/Guardian

Date