PATIENT REGISTRATION FORM

Patient Name _____Social Security Number_____-_____-_____
Date of Birth _____/_____/_____ Gender: M/F (Circle One) Married/Single/Divorced/Widowed/Partner
Address: _____City_____State_____Zip_____
Ethnicity: Not Hispanic or Latino ___ Hispanic or Latino___ Declined__ Preferred Primary Language_____
Race: Caucasian/White___ Black/African American__ Asian__ Native Hawaiian/Other Pacific Islander___
Native American Indian/Alaskan___ Other Race_____ Multiracial_____ Unknown/Declined_____
Home Phone (____)_____Cell Phone (___)_____
Would you be interested in having communication sent to you via your e-mail address? (example: appointment reminders) Y___ N____ E-mail Address:_____
Spouse Name_____ Date of birth_____SSN_____Phone_____
Employer Name _____Employer Phone Number: (___)_____
Employer Address _____City_____State_____Zip_____
Primary Care Physician (Name)_____ Copay amount $_____
Who referred you to our practice? _____

Person responsible for bill or parent (Complete only if different from patient)
Guarantor name: _____Social Security Number____-____-_____
Relationship to patient: (please check): ( ) self ( ) spouse or ( ) parent Date of birth ___-____-_____
Address: _____Phone number:_____
Employer Name: _____ Employer phone number: (___)_____
Employer Address: _____

Emergency contact: Name_____Relationship_____Phone_____
Address: _____City_____State_____Zip_____

FIRST INSURANCE INFORMATION (PRIMARY)
Plan Name: _____ I.D. Number: _____
Address: _____Group Number: _____
Policy Holder: _____Effective Date: _____
Policy Holder's Social Security # _____-_____-_____Policy Holder's Date of Birth_____

SECOND INSURANCE INFORMATION (SECONDARY)
Plan Name: _____I.D. Number:_____
Address: _____Group Number: _____
Policy Holder:_____ Effective Date:_____
Policy Holder's Social Security #:_____-_____-_____ Policy Holder's Date of Birth_____

I authorize release of any medical information necessary to process my claim to all insurance companies. I authorize direct payment of medical benefits to the provider. I permit a copy of this authorization to be used in place of the original. I consent for my photo to be taken. I understand that I am responsible for any amount not covered by insurance. I permit the faxing and electronic transmission of medical information to other health care providers, attorneys or insurance companies involved in my care. I give permission for messages to be left on my answering machine or by e-mail or text. I have received a copy of the Notice of Privacy Practices. I have received a copy of the financial policy for Fayetteville Surgical. In the event of non-payment of my accounts, I understand that I am responsible for all collection costs, including, but not limited to court costs and attorney fees. Fayetteville Surgical will receive 100% of all charges owed if the account is placed for collections.

Signature Patient_____ Date: _____
Signature responsible party _____Date:_____