

SURGICAL ASSOCIATES OF FREDERICKSBURG, LTD.
PATIENT REGISTRATION FORM

Patient's Name _____ Social Security # _____
Last First Middle Initial

Reason for visit _____ Referring MD _____ Primary MD _____

Date of Birth _____ Age _____ Sex _____ Marital Status _____ Home Phone # _____ Cell Phone # _____
Month / Day / Year

Preferred Pharmacy _____ Pharmacy Address _____

Home Address _____ E-mail Address _____
Street City State Zip

Mailing Address (if different from above) _____

Employer _____ Occupation _____

Work Address _____ Work Phone # _____
Street City State Zip

Spouse's Name _____ Date of Birth _____ Social Security # _____

Spouse's Employer _____ Work Phone # _____

Emergency Contact _____ Relationship _____ Phone Number # _____

IF THE PATIENT IS A MINOR OR STUDENT
(The party requesting care for a minor is responsible for payment)

Father's Name _____ Date of Birth _____ Social Security # _____

Father's Employer _____ Work Phone # _____

Mother's Name _____ Date of Birth _____ Social Security # _____

Mother's Employer _____ Work Phone # _____

INSURANCE INFORMATION

PRIMARY _____
Name of Insurance Co. Subscriber # Relationship to Insured

SECONDARY _____
Name of Insurance Co. Subscriber # Relationship to Insured

WORKERS COMPENSATION

Type of injury sustained _____ Date of Injury _____

Employer's Name & Address at time of injury _____

Contact Name _____ Contact Phone # _____

Worker's Compensation Carrier _____ Address _____

Contact Name _____ Contact Phone # _____ Claim # _____

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO OBTAIN OR RELEASE PATIENT INFORMATION

I hereby authorize the physician's office to release such information as may be necessary for claims to the insurance companies listed above. I also hereby authorize payment directly to Surgical Associates of Fredericksburg for any benefits otherwise payable to me, but not to exceed the regular charges for this period. I understand that I am financially responsible to the above physicians for charges not covered by this assignment. Patients not covered by insurance are responsible at the time of service for charges incurred or arrangements for payment must be made with the business office.

I also authorize the physician's office to release or obtain such information as may be necessary to assist in my medical treatment. This form will be placed in your chart and be applicable until such information is changed.

If this account is turned over to an attorney or collection agency for collection, the undersigned agrees to pay all costs of collections, including 33-1/3% in attorney fees, interest at 18% per annum, and court costs.

Signature _____ Date _____