

# ASSOCIATED SURGICAL GROUP - PATIENT REGISTRATION

Patient Name: \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
*LAST FIRST M.I.*

Address: \_\_\_\_\_  
*STREET/APT# CITY STATE ZIP*

Sex: M F Marital Status: S M D W Home Telephone#: ( ) \_\_\_\_\_

Patient Social Security #: \_\_\_\_\_ Cellular# ( ) \_\_\_\_\_

Patient Employer: \_\_\_\_\_ Work Telephone #: ( ) \_\_\_\_\_

Name of Spouse/or other contact \_\_\_\_\_ Telephone#: ( ) \_\_\_\_\_

Name of Parent (if patient is a minor): \_\_\_\_\_

Who referred you to this office: \_\_\_\_\_ Your Primary Care Doctor: \_\_\_\_\_

**Who is the insurance policy holder** \_\_\_\_\_ **(If not the patient, please fill out the following)**

Their Social Security#: \_\_\_\_\_ Their Birth Date: \_\_\_\_\_

Their Employer: \_\_\_\_\_ Their Work Telephone#: ( ) \_\_\_\_\_

**Is this a Workman's Compensation case?** ( ) Yes ( ) No

**(Please present your insurance card to the receptionist for copying.)**

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Patient Authorization:

I consent to treatment necessary in the care of the above named patient by any physician of Associated Surgical Group, S.C

I request that payment of authorized Medicare/Insurance benefits be made on my behalf to Associated Surgical Group, S.C.

I authorize release of all medical records to specified physicians and to CMS / Insurance Company if applicable.

I authorize fax transmittal of my medical records, if necessary.

Regardless of my insurance benefits, if any, I understand that I am responsible for all costs, including all collection and/or attorney costs, (which may be 33%-50% of the unpaid balance), in the event of a default, related to any service rendered by Associated Surgical Group, S.C.

I have read and understand the above; A) Consent to treatment, B) Payment authorization, C) Release of information, and D) Financial responsibility.

**X** \_\_\_\_\_  
*SIGNATURE- ALSO LIST RELATIONSHIP IF NOT BY PATIENT*

\_\_\_\_\_  
*DATE*

**PLEASE ALSO COMPLETE THE BACK SIDE OF THIS PAGE**

**To protect your privacy, and to insure that Associated Surgical Group remains within the HIPAA regulations, please provide the following information:**

Patient Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

How would you like to be contacted by phone? ( ) Home ( ) Work ( ) Cell

\_\_\_\_\_ Other, please explain and list \_\_\_\_\_

Do you want information about you left on your home answering machine? ( ) Yes ( ) No

Please list those persons whom this office may talk to regarding your medical information.

**(This will not give those listed authorization to obtain a copy of your medical record)**

Contact person/persons

<i>Name</i>	<i>Relationship</i>	<i>Phone#</i>
_____		
_____		
_____		

Please list additional Physicians who would have pertinent information about you.

<i>Physician Name</i>	<i>Specialty</i>	<i>Phone#</i>
_____		
_____		
_____		

I certify that the information provided above is correct to the best of my knowledge.

**X** \_\_\_\_\_  
*SIGNATURE- ALSO LIST RELATIONSHIP IF NOT BY PATIENT*

\_\_\_\_\_  
*DATE*