WILSON SURGICAL ASSOCIATES, P.A.

PATIENT REGISTRATION FORM

Name: _____ Social Security #: _____-_____-_____
Last First Middle Initial

Referring Doctor: _____ Family Doctor: _____

Date of Birth ____/____/_____ Age _____ Sex _____ Marital Status_____ Home Phone #_____ Cell Phone # _____

Ethnicity_____ Race_____ Primary Language_____

Pharmacy Name: _____ Pharmacy Phone # _____

Preferred Method of Communication: ☐Home Phone ☐Cell Phone ☐Work Phone ☐E-Mail ☐US Mail ☐Other_____

Home Address_____ Email 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 Company Subscriber # Relationship to Insured

SECONDARY_____
Name of Insurance Company Subscriber # Relationship to Insured

WORKER'S COMPENSATION (if applicable)

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 Wilson Surgical Associates, P.A. 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.

Signature_____ Date_____

4/2/14