SOUTHERN SURGICAL ASSOCIATES

PATIENT REGISTRATION FORM

PATIENT INFORMATION	RESPONSIBLE PARTY
First Name MI Last Name	First Name MI Last Name
Mailing Address	Mailing Address
City State Zip	City State Zip

Date of Birth	Sex	Marital Status
	[ ] M [ ] F	S M D W

Race: [ ] American Indian [ ] Asian [ ] Black or African American [ ] Native Hawaiian or Pacific Islander [ ] White/Caucasian [ ] Other Race [ ] Declined/Unavailable

Ethnicity: [ ]Non Hispanic [ ] Hispanic [ ]Declined/Unavailable

SS# Referring Physician

Home Phone # Work Phone # Cell Phone #

Email Would you like to receive Email from us? [ ] Yes [ ] No

Employer Name

Number you would prefer us to call? [ ] Home [ ] Work [ ] Cell Can we leave a message? [ ] Yes [ ] No

Emergency Contact

Name _____ Phone Number _____ Relationship _____

Pharmacy Name and Number

INSURANCE INFORMATION

Primary	Secondary
Insurance Company Name	Insurance Company Name
Policy Holder's Name	Policy Holder's Name
Policy Holder's Social Security Number	Policy Holder's Social Security Number
Policy Holder's Date of Birth	Policy Holder's Date of Birth
Policy Number	Policy Number
Group Number	Group Number

Do you have or expect to have Medicare or Medicaid?[ ] Yes [ ] No How did you hear about us? _____

-I hereby assign my insurance benefits to be paid directly to Southern Surgical Associates, PA.

-I understand that I am financially responsible for all non-covered services, copays, deductibles, and/or coinsurance. I authorize and give consent for my provicer to bill me directly for recommended services performed that are not covered under the terms of my health plan.

-I authorize the physician to release any medical information required to process this claim.

-I authorize my providers office to contact me by telephone to remind me of my appointments.

-A fee for no shows may apply

_____ _____ _____

Patient or Patient Representative Signature Date Relationship to Patient

updated 1/26