SOUTHWEST SURGERY OF YAVAPAI COUNTY, PC

PATIENT REGISTRATION

PATIENT NAME: _____
first middle last

DATE OF BIRTH:_____AGE:_____ MARITAL STATUS M S D W O

SOCIAL SECURITY #:_____GENDER: MALE OR FEMALE

MAILING ADDRESS:_____
street/po city state zip

(if different from above)
PHYSICAL ADDRESS:_____

HOME PHONE#:_____CELL/MESSAGE#_____

E-MAIL ADDRESS:_____SPOUSE'S NAME_____

EMPLOYED BY:_____WORK PHONE#_____

POLICY HOLDER/RESPONSIBLE PARTY NAME:_____
first middle last

DATE OF BIRTH:_____ SOCIAL SECURITY #:_____

MAILING ADDRESS:_____
street/po city state zip

EMPLOYED BY:_____WORK PHONE#_____

INCASE OF AN EMERGENCY CONTACT?_____PHONE#_____

WHO IS YOUR PRIMARY CARE PHYSICIAN?_____

WHICH PHYSICIAN REFERRED YOU TO OUR OFFICE?_____

DO YOU HAVE MEDICAL INSURANCE? YES NO

PRIMARY INSURANCE CARRIER:_____ID#_____

SECONDARY INSURANCE CARRIER:_____ID#_____

PLEASE SHOW YOUR INSURANCE CARD(S) AND DRIVERS LICENSE TO THE RECEPTIONIST

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED TO ME, INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF ANY INSURANCE BENEFITS. I AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS TO SOUTHWEST SURGERY OF YAVAPAI COUNTY, PC FOR ALL SERVICES RENDERED TO ME. I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCEED THIS CLAIM OR TO BENEFIT ANY PHYICIANS WHO MIGHT BE INVOLVED IN MY MEDICAL TREATMENT.

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN PRESENTED WITH A COPY OF SOUTHWEST SURGERY'S NOTICE OF PRIVACY PRACTICES AND HAVE SIGNED THEIR FINANCIAL POLICY.

I DO ____ , **I DO NOT**____ AUTHORIZE THE STAFF OF SOUTHWEST SURGERY TO LEAVE A DETAILED MESSAGE REGARDING ANY MEDICAL INFORMATION.

SIGNED:_____PHONE:_____DATE:_____