Patient Label

Registration Form

(Please Print)

PATIENT'S LAST NAME: | FIRST NAME: | MIDDLE INTIAL:

IS THIS YOUR LEGAL NAME? ☐ YES ☐ NO | MAIDEN OR PREVIOUS NAME: | DRIVERS LICENSE #:

HOME ADDRESS: | HOW LONG AT THIS ADDRESS: | HOME PHONE NO: ( )

CITY: | STATE: ZIP: | CELL PHONE NO: ( )

BIRTH DATE: AGE: | SEX: MARITIAL STATUS: SINGLE/MARRIED/ DIVORCED | STUDENT STATUS: ☐ FULL TIME ☐ PART TIME

PATIENT'S SOCIAL SECURITY NO: | PATIENT'S EMPLOYER: | OCCUPATION:

EMPLOYMENT ADDRESS: | CITY: STATE: ZIP: | WORK PHONE PHONE:

IS THIS SURGERY RELATED TO AN INJURY OR TRAUMA? ☐ YES ☐ NO INJURY DATE: | MESSAGES CAN BE LEFT AT : ☐ HOME ☐ WORK ☐ CELL

WHERE DID YOUR INJURY OCCUR: | CLAIM#: _____

WORK - DID YOU FILE A WORKERS COMP CLAIM? YES/NO | ADJUSTER NAME & PHONE#: _____

HOME – DID YOU FILE A HOME OWNERS INSURANCE CLAIM? YES/NO | CLAIM#: _____

AUTO - DID YOU FILE AN AUTO INSURANCE CLAIM? YES/NO | CLAIM#: _____

SCHOOL – DID YOU FILE AN ACCIDENT CLAIM? YES/NO | SCHOOL NAME: _____

Insurance Information

PRIMARY INSURANCE : | SUBCRIBER OR ID NO: | GROUP NO:

SUBSCRIBER'S NAME: | SUBSCRIBER'S DOB: | SUBSCRIBER'S SS NO.:

PATIENT'S RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

SECONDARY INSURANCE: | SUBCRIBER OR ID NO: | GROUP NO:

SUBSCRIBER'S NAME: | SUBSCRIBER'S DOB: | SUBSCRIBER'S SS NO.:

PATIENT'S RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

CONTACT PERSON UPON DISCHARGE , NAME: | RELATIONSHIP: | PHONE NO: ( )

In Case Of Emergency

NAME OF LOCAL FRIEND OR RELATIVE (NOT LIVING AT THE SAME ADDRESS): | RELATIONSHIP: | HOME NO: ( ) WORK NO: ( )

Statement to Permit of Medicare Benefits and/or Insurance to Provider (Assigned Claims)

I certify that the information given by me in applying for payment under Title XVIII or XIX of the Social Security Act is correct and I request that the payment of authorized benefits be made on my behalf. I assign benefits payable for facility services to Congress Medical Surgery Center. I assign benefits payable for anesthesiologist/anesthetist services to those who provided the services. I agree that I am responsible for payment of services not covered by Medicare, the Medicare deductible, and co-insurance. I authorized any holder of medical or other information about me to release to the Social Security Administration, its intermediaries or carriers, and any information needed for this or a related Medicare claim. I hereby assign payment of any surgical, medical and/or major medical benefits directly to Congress Medical Surgery Center and to attending anesthesiologist/anesthetist, otherwise payable to me for services rendered. I authorize Congress Medical Surgery Center to release any information acquired in the course of my surgical procedure for the purpose of insurance benefit payment. I agree that I will be responsible for all charges not paid by Medicare and/or my insurance company.

Patient/Guardian Signature: _____ **Date:** _____