SURGICAL ASSOCIATES OF FREDERICKSBURG, LTD.

PATIENT REGISTRATION FORM

Patient's Name ______________________________ Social Security #__________-________-________
Last First Middle Initial

Reason for visit ______________________ Referring MD ____________________ Primary MD____________________

Date of Birth ________________ Age ______ Sex ______ Marital Status _________ Home Phone # _______________ Cell Phone # _________________
Month / Day / Year

Ethnicity: ___________________________ Race: ___________________________ Primary Language: ______________________

Preferred Pharmacy_________________________________Pharmacy Address____

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

Home Address ______________________________E-mail 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 Co. Subscriber # Group # Address Relationship to Insured

SECONDARY ____
Name of Insurance Co. Subscriber # Group # Address Relationship to Insured

WORKERS 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 Surgical Associates of Fredericksburg 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, as well as obtain prescription history via electronic RX database. This form will be placed in your chart and be applicable until such information is changed.

If this account is turned over to an attorney or collection agency for collection services, the undersigned agrees to pay all costs of collections, inclusive of 29% in collection agency fees, interest at 18% per annum, court costs, and any additional costs associated with collection of outstanding balances to Surgical Associates of Fredericksburg.

Signature: ______________________________ Date: ______________________________