Acct # _____ **Patient Registration**

Last Name _____ **First Name** _____ **M.I.** _____ **M** _____ **F** _____ **Date of Birth** _____ **Age** _____ **Address** _____ **City** _____ **State** _____ **Zip** _____ **Home Ph** _____ **Work Ph** _____ **Cell Ph** _____ **Soc Sec** _____

Marital Status M S D W Spouse Name _____

Employment Full Time _____ Part Time _____ Not Employed _____ Past/present employer _____ Date of Retirement _____ Is this Workers Comp? Y N Auto accident ? Y N Last date worked _____ Injury date _____ Entitled to black lung benefits ? Y N

Primary Care Physician _____ MD / DO

Referring Physician _____ MD / DO Cardiologist _____ MD / DO

INSURANCE INFORMATION

Primary Insurance _____ Group Policy Y N Policy Holder _____ Soc Sec # _____ DOB _____ Policy Holder employer _____ Date of Retirement _____

Address _____

Secondary Insurance _____ Group Policy Y N Policy Holder _____ Soc Sec # _____ DOB _____ Policy Holder employer _____ Date of Retirement _____

Address _____

Emergency Contact (other than spouse) _____ Phone _____ Relationship _____

May we leave messages with a family member? Y N On your answering machine? Y N

I have received the Notice of Privacy Practices from The Surgical Group of Southwest Michigan. I authorize the release of my protected health information for treatment, payment and healthcare operations. I authorize and request my insurance company and/or Medicare to pay directly to The Surgical Group of Southwest Michigan payment for services rendered to me.

I understand that my insurance carrier may pay less than the actual bill of services. I agree to be responsible for payment of all services on my behalf or my dependent.

Signature _____ Date _____

(Signature of patient or parent/guardian if minor)

revised 11/07