PHILADELPHIA SURGI-CENTER, INC. — PATIENT REGISTRATION

PATIENT NAME _____ DATE OF BIRTH ____/____/____
(LAST) (FIRST) (MI)

ADDRESS _____
(#/STREET) (CITY) (STATE) (ZIP)

HOME PHONE # (____) - ____ - ____ WORK PHONE # (____) - ____ EXT ____

CELL PHONE# (____) - ____ - ____ SEX: ☐ MALE ☐ FEMALE

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ OTHER

SOCIAL SEC # ____ - ____ - ____ RACE: ☐ CAUCASION ☐ AFRICIAN AMERICAN ☐ HISPANIC ☐ OTHER

EMPLOYER'S NAME: _____ RELIGION *(OPTIONAL)*: _____

PRIMARY CARE PHYSICIAN: _____ PRIMARY CARE PHYSICIAN TELEPHONE: (____) ____

EMERGENCY CONTACT: _____ EMERGENCY TELEPHONE: (____) ____ - ____

IF THE PATIENT IS A MINOR, PARENT/GUARDIAN: _____ PARENT / GUARDIAN TELEPHONE: (____) ____ - ____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ TELEPHONE (____) - ____

IDENTIFICATION # _____ GROUP/PLAN # _____

RELATION TO INSURED ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

IF OTHER THAN SELF: NAME OF INSURED _____ D.O.B. _____ SSN# _____

SECONDARY INSURANCE _____ TELEPHONE (____) ____

IDENTIFICATION # _____ GROUP/PLAN # _____

RELATION TO INSURED ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

IF OTHER THAN SELF: NAME OF INSURED _____ D.O.B. ____/____/____ SSN# ____ - ____ - ____

ACCIDENT INFORMATION *(if applicable)*

ARE YOU SEEING THE DOCTOR BECAUSE OF AN ACCIDENT? ☐ YES* ☐ NO DATE OF ACCIDENT: ____/____/____

TYPE OF ACCIDENT: ☐ MOTOR VEHICLE ACCIDENT ☐ WORKERS' COMPENSATION** ☐ OTHER _____

INSURANCE COMPANY: _____ TELEPHONE (____) ____

CLAIM# _____ ADJUSTER'S NAME _____

ADDRESS _____

THE FOLLOWING IS FOR THE RELEASE OF MEDICAL INFORMATION TO YOUR INSURANCE CARRIER AND ASSIGNMENT OF BENEFITS TO OUR FACILITY.

I hereby authorize release of medical information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to PHILADELPHIA SURGI-CENTER, INC. I understand that I am financially responsible for any balance not covered by my insurance carrier. I UNDERSTAND THAT IN THE EVENT OF TERMINATION OF BENEFITS AND/OR LACK OF INSURANCE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES RENDERED, AND THE PHILADELPHIA SURGI-CENTER/GABAY, ENT & ASSOCIATES/Gabay, Gottlieb, & Assoc.PC. WILL NOT BE RESPONSIBLE FOR ANY FINANCIAL COST ACCRUED. A copy of this signature is as valid as the original.

Signature of Patient or Guardian X _____ **Date** _____

FOR PATIENTS WITH MEDICARE INSURANCE ONLY (IN ADDITION TO THE ABOVE):

I request that payment of authorized Medicare benefits be made to PHILADELPHIA SURGI-CENTER, INC. for services furnished to me by the facility. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services

Beneficiary Signature X _____ **Date** _____

FOR PATIENTS WITH **MEDICARE & SECONDARY (SUPPLEMENTAL) INSURANCE** (IN ADDITION TO BOTH ABOVE):

I hereby give PHILADELPHIA SURGI-CENTER, INC. permission to ask for Medicare Supplemental Insurance payments for my medical care and I understand that my Secondary Insurance Carrier needs information about me and my medical condition to make a decision about these payments. I request that payment of authorized Medicare Supplemental benefits be made to the PHILADELPHIA SURGI-CENTER, INC. for any services furnished to me by the facility.

Beneficiary Signature X _____ **Date** _____

☐ have reviewed the information above and there are no changes _____ _____
Date **Signature**

☐ have reviewed the information above and there are no changes _____ _____
Date **Signature**