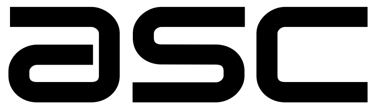

ASHLAND SURGERY CENTER

REGISTRATION

Please print

PATIENT INFORMATION

First Name______________________Middle________________Last________________________

AKA: (nickname) ________________________SSN____________________________

Date of Birth: ____/____/____ Age: _________ Sex: M F

Marital Status: (circle one): Single / Married / Divorced / Widowed / Other _______________

Race: (Caucasian) (Hispanic) (Black) (Native American) (Asian) (Other) (Declined)

Ethnicity: (Hispanic) (Non-Hispanic) (Declined)

Physical Address:
Street___________________________ City/ State______________________ Zip Code___________

Mailing Address:
Street____________________________________ City/ State___________________________

Home Phone ( ) ________________________ Work Phone ( ) _________________________

Patient Employment Status: (circle one) Full Time Part Time Retired Not Currently Employed

Employer_______________________________ Phone # _____________________

EMERGENCY CONTACT INFORMATION

Contact Name_____________________________ Relationship_____________________________

Home Phone: ( ) _____________ Work Phone ( ) _____________ Cell Phone _______________

Can we share information with emergency contact? (Y) (N)

Please list name/s of any others we can share information with______________________________

INSURANCE INFORMATION

PRIMARY INSURANCE: (name) ___________________________________

Subscriber's Name (as it appears on card) ____

ID# __________________________ Group # _______________________________

Relationship to Patient (if other than self) _______________Subscribers DOB: ___________________

Subscriber's SSN ______________________________ Subscribers Employer____________________

PAGE CONTINUES ON BACK

SECONDARY INSURANCE: (name) ______________________________

Subscriber's Name (as it appears on card) ____

ID#______________________________ Group#___________________________

Relationship to Patient (if other than self) _______________Subscribers DOB: _____________

Subscriber's SSN ______________________________

INJURY INFORMATION
(If applicable)

Date of Injury_____________________________

Work Compensation Insurance (circle one) Saif Liberty Northwest State Farm

Other (specify): ___________________

Adjuster's Phone #:___________________________ Claim #_______________________________

Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Ashland Surgery Center for any services furnished 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 to determine these benefits payable for related services.

____ ___________________

Patients Signature **Date**

Insurance Authorization of Benefits/Information Release:

I, the undersigned authorize payment of medical benefits to Ashland Surgery Center for any services furnished me by the physician. I understand that I am financially responsible for any amount not covered by my insurance. I also understand that my secondary insurance will be billed, one time, as a courtesy. If they do not pay within 60 days of being billed the balance will become my responsibility. I also authorize you to release to my insurance company, or their agent, information concerning healthcare, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

____ _________________

Patient signature (Parent/Guardian if child is under 18) **Date**