NorthPoint Surgical Specialists **Patient Registration Form**

PATIENT INFORMATION

Name: Birth Date: S.S. No.:

Street: City: State: Zip:

Home Phone No. Cell No.:

Email: _____ Contact Preference:_____ How did you hear about us:_____

Sex: Marital Status Language: Race: Ethnicity:

Employer: _____ Work Phone No: _____ Ext: _____

Spouse (or Parent if minor): _____ Spouse Phone No.: _____ Ext: _____

Pharmacy: _____ Preferred Lab: _____

PERSON RESPONSIBLE FOR PAYMENT

Name: S.S. No.:

Street: City: State: Zip:

Home Phone No:_____ Ext: _____ Work: _____ Ext:_____

Employer: _____ Work Related Injury? _____

Date of Injury: _____ Has an L&I claim been filed?_____ If yes, What is the claim #? _____

Employer – Street: _____ City: _____ State: _____ Zip: _____

Spouse or Parent Name: _____ Spouse or Parent S.S. No.:_____

Spouse or Parent Employer: _____ Work Phone No.:_____

PERSON TO CALL IN CASE OF EMERGENCY

Name:_____ Relationship: _____

Street: _____ City: _____ State: _____ Zip: _____

Home Phone No.: Work Phone No.: _____ Cell No.: _____

REFERRING PHYSICIAN

Name: _____ Phone No.: _____

Street: _____ City: _____ State: _____ Zip: _____

I, the patient or patient's guardian, accept the responsibility for the payment of all charges at the time the services are rendered. Although I am responsible for the entire amount, including the portion covered by insurance, I also understand that assistance may be provided in filling out necessary forms related to these services when requested by me.

IF YOU HAVE YOUR INSURANCE CARD PRESENT FOR COPYING, YOU DO NOT NEED TO FILL THIS PAGE OUT

INSURANCE INFORMATION

Please have your card available so that we can make a copy.

Primary

Insurance Company Name:

Street: City: State: Zip:

Policy Holder's Name: Policy Holder's S.S. No.: _____

Policy Holder's Date of Birth: Policy Number:

Group No.: _____

Does Insurance Require Pre-certification? _____ Yes _____ No

If "yes" list phone number for authorization of service _____

_____

Secondary

Insurance Company Name:

Street: City: State: Zip:

Policy Holder's Name: Policy Holder's S.S. No.: _____

Policy Holder's Date of Birth: Policy Number:

Group No.: _____

Does Insurance Require Pre-certification? _____ Yes _____ No

If "yes" list phone number for authorization of service _____

_____

BENEFITS AUTHORIZATION

I request that payment of authorized benefits be made either to me on my behalf or to NorthPoint Surgical Specialists for any services furnished to me.

Patient/Guardian Signature _____

Date: _____ Relationship to patient: _____