



PATIENT REGISTRATION FORM

Patient Information

Patient Name First Middle Initial Last Home Phone Cell Phone
Sex: M F Date of Birth Social Security# Marital Status S M W D SEP
Address City ST Zip
Employer Name Work phone
Employer Address City ST Zip

Insurance Information:

\*If you are not the primary policy holder, please make sure to fill in the insured's SS# and DOB

Primary Insurance Group# Subscriber#

Insurance address Insured's SS#

Name of Insured Relationship to patient Birth date

Secondary Insurance Group# Subscriber#

If Medicare is secondary please explain reason

Insurance address Insured's SS#

Name of Insured Relationship to patient Birth date

Medicaid# Passport Doctor

Accident/Injury Information

Work Related Injury: Y N Date of injury Claim#

Motorized Vehicle Accident: Y N Date of accident Type of Vehicle

MVA Insurance Name Policy holder

Insurance address Ins Phone Attorney name

Release of Information/Assignment of Insurance Benefits and Acknowledgement of Privacy Policy

This is to certify that I, the undersigned, hereby consent to and authorize the administration and performance of all medical treatment which may be considered necessary or advisable. I authorize the release of any information necessary to obtain reimbursement for health care provided for all dates of service. I also authorize all payors to make payment of all physician benefits directly to SilverBow Surgical Associates (Dr. Raiser and Dr. Gulley). I understand that I am personally financially responsible to SilverBow Surgical Associates for all charges not covered by the assignment. In addition, I acknowledge that I have received a copy of the Notice of Privacy Practices for SilverBow Surgical Associates, and I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that SilverBow Surgical Associates is not required to agree to the restrictions that I may request.

Signature

Date

Emergency Contact/Individuals who may Receive Health Information from SilverBow Surgical Associates, either in person or over the telephone. This may include appointment times, test results, patient progress and medications. This list will remain in effect for one (1) year or until I notify SilverBow Surgical Associates otherwise in writing.

Emergency Contact Relationship Phone

Those with whom your care may be discussed (1) (2)

(3) (4) (5)