Surgical Consulting, PLLC Patient Registration Form

Today's Date _____ Physician who referred to our office _____

Address _____ Phone _____

Name _____
First Middle Last

Marital Status: Minor ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐

Birth Date _____ Social Security# _____ Sex M ☐ F ☐

Address: _____
Street City State Zip

Primary Phone _____ Home or Cell ☐ ☐ Secondary Phone _____ Home or Cell

Email Address _____

Pharmacy Name _____

Address _____ Phone _____

Primary Care Physician Name _____

Address _____ Phone _____

Employment Status: Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐

Employer Name _____ Occupation _____

Employer Address _____ Phone _____

Spouse Name _____ Birth Date _____ Social Security# _____

Spouse's Employer Name _____ Occupation _____

Spouse's Employer Address _____ Phone _____

Emergency Contact (other than spouse)

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

HEALTH INSURANCE INFORMATION

Primary Carrier: _____ ID#: _____ Gr.#_____

Subscriber _____ Relationship _____

DOB _____ SS# _____

PPO ☐ HMO ☐ REFERRAL NEEDED YES ☐ NO ☐ Specialist Co-Pay amount $ _____

Secondary Insurance _____ ID# _____ Gr.# _____

Subscriber _____ Relationship _____

DOB _____ SS# _____

PPO ☐ HMO ☐ REFERRAL NEEDED YES ☐ NO ☐ Specialist Co-Pay amount $ _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Surgical Consulting, PLLC or insurance company to release any information required to process my claims.

Patient/Guardian Signature _____ Date _____