

Surgical Wellness Center, Inc.

REFERRED BY: Doctor Yellow Pgs.
 Prologue Lawyer
 Friend/Relative Other

PATIENT REGISTRATION (Please Print)

PATIENT NAME			First	Middle	Last	NICKNAME	
SEX	DATE OF BIRTH	AGE	MARITAL STATUS		SOCIAL SECURITY NUMBER		HOME PHONE NO.
<input type="checkbox"/> Male <input type="checkbox"/> Female			<input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> Sep				()
ADDRESS Street			City		State	Zip	DRIVER'S LICENSE
ARE YOU			OCCUPATION OR, IF STUDENT, GRADE				St. #
<input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student							WORK OR SCHOOL PHONE NO.
EMPLOYER OR SCHOOL NAME & ADDRESS Street			City		State	Zip	()
E-MAIL ADDRESS						PHARMACY PHONE NO.	
						()	

PERSON FINANCIALLY RESPONSIBLE (If different from above)

NAME		PATIENT'S RELATIONSHIP TO INSURED		OCCUPATION	
ADDRESS Street		<input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other			
City		SOCIAL SECURITY NO.		HOME PHONE NO.	
State		EMPLOYER NAME		()	
Zip				EMPLOYER PHONE NO.	
				()	

PRIMARY INSURANCE

If no insurance please check

INSURANCE COMPANY			INSURED (if other than patient please complete)		
INSURANCE COMPANY NAME OR MEDICARE INFORMATION			POLICY IN NAME OF (insured)		HOME PHONE NO.
POLICY NUMBER			INSURED'S ADDRESS Street		()
INSURANCE COMPANY ADDRESS Street			City		State
City			State		Zip
INSURANCE COMPANY PHONE NUMBERS			PATIENT'S RELATIONSHIP TO INSURED		DATE OF BIRTH
Verifying: ()			<input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other		SEX
Claim: ()			EMPLOYER'S NAME & PHONE NO.		<input type="checkbox"/> M <input type="checkbox"/> F
			SOC. SEC. NO. OF INSURED		

SECONDARY INSURANCE

INSURANCE COMPANY			INSURED (if other than patient please complete)		
INSURANCE COMPANY NAME OR MEDICARE INFORMATION			POLICY IN NAME OF (insured)		HOME PHONE NO.
POLICY NUMBER			INSURED'S ADDRESS Street		()
INSURANCE COMPANY ADDRESS Street			City		State
City			State		Zip
INSURANCE COMPANY PHONE NUMBERS			PATIENT'S RELATIONSHIP TO INSURED		DATE OF BIRTH
Verifying: ()			<input type="checkbox"/> Self <input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other		SEX
Claim: ()			EMPLOYER'S NAME & PHONE NO.		<input type="checkbox"/> M <input type="checkbox"/> F
			SOC. SEC. NO. OF INSURED		

EMERGENCY CONTACT NAME		RELATIONSHIP TO PATIENT	PHONE NO.
			()
FAMILY DOCTOR			PHONE NO.
			()

If patient is under 18 years of age, please complete the following:

ACCOMPANYING ADULT'S NAME	RELATIONSHIP TO PATIENT	SIGNATURE

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize Surgical Wellness Center, Inc. to release medical information that may be necessary to request claim reimbursement from my insurance company to whom claims have been submitted.
 I certify that the information I have reported regarding my insurance coverage is correct. I also assign the claim payments to be made payable to Surgical Wellness Center, Inc. directly and I understand that any overpayment will be refunded to me from the doctor's office.
 I understand that I will be responsible for any unpaid balance. I further understand that, if I have an insurance with which Surgical Wellness Center, Inc. participates, I will be responsible for any unpaid balance remaining after 45 days.
 I understand that if any unpaid balance necessitates legal action (attorney/court fees/collection agency fees) to collect this balance, I will be responsible for all attorney, court costs and collection agency fees.

Signature _____ Date _____
(insured or authorized person)