NORTHWEST SURGICAL SPECIALISTS
PATIENT REGISTRATION
PLEASE PRINT

PATIENT_____ ☐M DATE_____
LAST FIRST MIDDLE ☐F
ADDRESS_____ HOME #_____
CELL# _____
CITY_____STATE_____ZIP_____ WORK# _____

PATIENT EMPLOYER_____ BIRTHDATE_____ AGE____

ADDRESS_____ SOC. SEC#_____

CITY_____STATE_____ZIP_____ MARITAL STATUS:
☐ SINGLE ☐MARRIED ☐OTHER

OCCUPATION_____
SIGNIFICANT OTHER NAME_____

PRIMARY CARE PHYSICIAN_____ REFERRING PHYSICIAN_____

PERSON RESPONSIBLE FOR BILL, IF NOT PATIENT
NAME_____
ADDRESS_____
CITY_____STATE____ZIP_____
RELATIONSHIP TO PATIENT_____

INSURANCE INFORMATION
INSURANCE_____
ID#_____GROUP#_____
SUBSCRIBER NAME_____
SUBSCRIBER DATE OF BIRTH___/___/_____
PATIENT RELATION TO SUBSCRIBER:
☐ SELF ☐ SPOUSE ☐ CHILD ☐ DEPENDANT

IS THIS A WORK RELATED OR AUTO INJURY?
YES ☐ **NO** ☐
CLAIM #: _____INJURY DATE: _____
CLAIMS MANAGER: _____
CONTACT PHONE#_____

DO WE HAVE YOUR PERMISSION TO LEAVE A MESSAGE:
AT HOME? YES ☐ NO ☐
AT WORK? YES ☐ NO ☐
CELL PHONE? YES ☐ NO ☐

IN CASE OF EMERGENCY, LOCAL FRIEND OR RELATIVE (NOT LIVING AT SAME ADDRESS)
NAME_____RELATIONSHIP_____DAYTIME #_____

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician. I am financially responsible for any balance due. I also authorize the doctor or insurance company to release information required for this claim.
I consent to the release of medical information from or to other doctors and health care institutions as is necessary for my care and treatment and have been offered a copy of this practice's privacy practices.

SIGNED: _____DATE:_____