



Surgery Group of Grand Island
REGISTRATION INFORMATION

Today's Date: Social Security #:

Patient Name:

First Middle Last

Street Address: Mailing Address:

City: State: ZIP:

Sex: M F Date of Birth: Marital status: Single Married Widow Separated Divorced

Race: White / Asian / African American / Other Ethnicity: Hispanic/Latino Other

Language Spoken Circle One: English Spanish Other (please list)

Home Phone: May we leave a message? YES NO

Work Phone: May we leave a message? YES NO

Cell Phone: May we leave a message? YES NO

Patient employed by: Full Time Part Time

Name of the Doctor who referred you to us:

Spouse (or Responsible Party) Name: Phone:

Spouse (or Responsible Party) Date of Birth:

Employer:

Work Phone:

Is this visit work related? Yes No If yes, Date of Injury:

Name of Primary Insurance: Is this provided by an Employer? Yes No

Group #: ID #: Copay: \$ Effective Date:

Subscriber: DOB: SS#:

Patient's relationship to subscriber: Self Wife Husband Child Other

Name of Secondary Insurance: Is this provided by an Employer? Yes No

Group #: ID #: Copay: \$ Effective Date:

Subscriber: DOB: SS#:

Patient's relationship to subscriber: Self Wife Husband Child Other

In case of an emergency, who should be notified?

Relationship: Phone:

Are you ALLERGIC to any medicines?

Are you DIABETIC? Yes No Are you taking BLOOD THINNERS (Coumadin, Plavix, Warfarin, Aspirin)? Yes No

Do you authorize Surgery Group to disclose your Health Information? (other than Physicians) Yes No (See Release Form)

ASSIGNMENT OF INSURANCE BENEFITS

I hereby give authorization for payment of insurance benefits to be made directly to Surgery Group of Grand Island, and any assisting physicians or surgeons, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I hereby authorize Surgery Group of Grand Island to release all information to insurance companies, attorneys, or other physicians to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as original.

Signature: Date:

NOTICE OF PRIVACY PRACTICES (Please check one and sign below)

I would like a copy of the "Notice of Privacy Practices." I do not wish to receive a copy.

Signature: Date: