# Surgery Group of Grand Island
# REGISTRATION INFORMATION

***Please fill out this form completely***

**Today's Date:** ________________________ **Social Security #:** ______________________________

**Patient Name:** ______________________________________________________________________

First Middle Last

**Street Address:** ______________________________________________________________________

**City:** _______________________________________ **State:** _____________ **ZIP:** _______________

**Home Phone:** _______________________ **Work:** _______________________ **Cell:** _____________________

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

**Patient employed by:** ________________________________________________ **Full Time Part Time**

**Business Address:** ____________________________________________________________________

**Spouse (or Responsible Party) Name:** ________________________________________ **Phone:** ______________

**Spouse's Employer:** ________________________________________________ **Phone:** ______________

**Employer Address:** ______________________________________________________________________

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

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

**Subscriber:** __________________________________ **DOB:** ______________ **SS#:** ______________________

**ID #:** ___________________________ **Group #:** _______________ **Copay: $**________ **Effective Date:** ____________

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

**Subscriber:** __________________________________ **DOB:** ______________ **SS#:** ______________________

**ID #:** ___________________________ **Group #:** _______________ **Copay: $**________ **Effective Date:** ____________

***Please check with your insurance company for any Pre-Certification and / or Second Surgical Opinion requirements.***

**In case of an emergency, who should be notified?**

**1)** __________________________________________ **Relationship:** ____________ **Phone:** __________________

**2)** __________________________________________ **Relationship:** ____________ **Phone:** __________________

**Name of the Doctor who referred you to us?** ____________________________________________________________

**Are you ALLERGIC to any medicines?** ________________________________________________________________

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

**Is there anyone you authorize Surgery Group to disclose your Protected Health Information to? Yes No (see back of 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:** ______________________