

SOUTHWEST SURGERY OF YAVAPAI COUNTY, PC
PATIENT REGISTRATION

PATIENT NAME:

_____ first middle last

DATE OF BIRTH: _____ AGE: _____ MARITAL STATUS M S
D W O

SOCIAL SECURITY #: _____ GENDER: MALE OR
FEMALE

MAILING
ADDRESS: _____
street/po city state zip

(if different from above)

PHYSICAL
ADDRESS: _____

HOME PHONE#: _____ CELL/
MESSAGE# _____

E-MAIL ADDRESS: _____ SPOUSE'S
NAME _____

EMPLOYED BY: _____ WORK
PHONE# _____

**POLICY HOLDER/RESPONSIBLE PARTY
NAME:** _____

first middle last

DATE OF BIRTH: _____ SOCIAL SECURITY
#: _____

MAILING
ADDRESS: _____
street/po city state zip

EMPLOYED BY: _____ WORK
PHONE# _____

IN CASE OF AN EMERGENCY CONTACT?
PHONE# _____

WHO IS YOUR PRIMARY CARE PHYSICIAN?

WHICH PHYSICIAN REFERRED YOU TO OUR OFFICE?

DO YOU HAVE MEDICAL INSURANCE? YES NO

PRIMARY INSURANCE
CARRIER: _____ ID# _____

SECONDARY INSURANCE

CARRIER: _____ ID# _____

PLEASE SHOW YOUR INSURANCE CARD(S) AND DRIVERS LICENSE TO THE RECEPTIONIST

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED TO ME, INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF ANY INSURANCE BENEFITS. I AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS TO SOUTHWEST SURGERY OF YAVAPAI COUNTY, PC FOR ALL SERVICES RENDERED TO ME. I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCEED THIS CLAIM OR TO BENEFIT ANY PHYSICIANS WHO MIGHT BE INVOLVED IN MY MEDICAL TREATMENT.

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN PRESENTED WITH A COPY OF SOUTHWEST SURGERY'S NOTICE OF PRIVACY PRACTICES AND HAVE SIGNED THEIR FINANCIAL POLICY.

I DO _____, I DO NOT _____ AUTHORIZE THE STAFF OF SOUTHWEST SURGERY TO LEAVE A DETAILED MESSAGE REGARDING ANY MEDICAL INFORMATION.

SIGNED: _____ PHONE: _____ DATE: _____
