MERCER COUNTY SURGERY CENTER PATIENT REGISTRATION FORM

PATIENT INFORMATION

NAME_____ DATE OF BIRTH _____ AGE_____

ADDRESS_____ TELEPHONE (HOME) _____

CITY_____ BUSINESS PHONE _____

STATE, ZIP _____ CELL/MOBILE PHONE _____

EMAIL ADDRESS _____ MARITAL STATUS: S M W D GENDER: F M

PRIMARY CARE PHYSICIAN _____ SOCIAL SECURITY # _____

EMPLOYER _____ POSITION _____

ADDRESS _____

CITY, STATE, ZIP _____

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE_____

ADDRESS _____CITY, STATE, ZIP_____

MEMBER # _____GROUP # _____

NAME OF INSURED_____DATE OF BIRTH_____

RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE INFORMATION

NAME OF INSURANCE_____

ADDRESS _____CITY, STATE, ZIP_____

MEMBER # _____GROUP # _____

NAME OF INSURED_____DATE OF BIRTH_____

RELATIONSHIP TO PATIENT _____

EMERGENCY NOTIFICATION

CONTACT _____ RELATIONSHIP _____

TELEPHONE NUMBER(S) _____

RELEASE OF AUTHORIZATION OF BENEFITS: I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in place of the original.

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PATIENT/GUARDIAN/REPRESENTATIVE SIGNATURE DATE OF SERVICE