PARK PLACE
SURGICAL HOSPITAL
A Joint Venture of Park Place Surgical Hospital & Our Lady of Lourdes Regional Medical Center

Registration Form

Please fill out this entire form to the best of your knowledge. Once completed bring this up to the Receptionist with your Insurance card (s) and Driver's License:

Physician's Information:

Surgeon's Name: _____ Date of Surgery: _____

Patient's Information:

Patient's Last Name: _____ First: _____ Middle Initial: _____

Mailing Address: _____ City, State, Zip code: _____

Sex: □ Male □ Female Social Security #: _____ Date of birth: _____

Home Phone Number: _____ Work: _____ Cell: _____

Marital Status: _____ Race: _____ Religion: _____

Nationality: _____ Primary Language: _____

Patient's Employer: _____ Employer's Phone number: _____

Insurance Information: **Please fill this section out using your insurance card (s)**

Please select one of the following: □ Health Insurance □ Worker's Comp □ Attorney □ Self pay

If this is accident/injury related: Accident/Injury/Onset Date: _____/_____/_____

Primary Insurance Company: _____ Phone Number: _____

Subscriber's Name: _____ Social Security #: _____

Date of Birth: _____ Address: _____

Policy #: _____ Group #: _____ Effective Date: _____

Patient's Relationship to Subscriber: □ Self □ Spouse □ Child Other: _____

Secondary Insurance Company: _____ Phone Number: _____

Subscriber's Name: _____ Social Security #: _____

Date of Birth: _____ Address: _____

Policy #: _____ Group #: _____ Effective Date: _____

Patient's Relationship to Subscriber: □ Self □ Spouse □ Child Other: _____

Continued on back →

Tertiary Insurance Company: _____ Phone Number: _____

Subscriber's Name: _____ Social Security #: _____

Date of Birth: _____ Address: _____

Policy #: _____Group #: _____ Effective Date: _____

Patient's Relationship to Subscriber: □ Self □ Spouse □ Child Other: _____

Responsible Party Information: (Complete only if the patient is a minor, under the age of 18)

Responsible Party Name: _____ Social Security #: _____

Date of Birth: _____ Address: _____

Home Phone #: _____ Alternate Phone #: _____

In Case of an Emergency:

Nearest Relative not living at your address: _____

Home Phone #: _____ Alternate Phone #: _____

The above information is true to the best of my knowledge. I authorize my Insurance benefits be paid directly to the Hospital. I understand that I am financially responsible for any balance. I also authorize the Hospital or Insurance Company to release any information required to process my claims.

Patient/Guardian Signature: _____**Date/Time:** _____

Office Use Only

Entered By: