Park Place Surgical Hospital

Registration Form

Surgery Date: ____________________ Surgeon's Name: ____________________

PATIENT INFORMATION

Patient's Last Name: ***First:*** ***M.I.***

Mailing Address: ***City:*** ***State:*** ***Zip Code:***

Sex: ☐ M ☐ F ***Social Security #:*** - - ***Birth Date(mm-dd-yyyy)*** - -

Home Phone No: ( ) ***Work No.:*** ( ) ***Pager:*** ( ) ***Cell No:*** ( )

Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

Race: ☐African American ☐Asian ☐Caucasian ☐Hispanic ☐Native American ☐Other

Religion: ______________ ***Nationality***: ____________ ***Language Spoken***: ____________

Employers Name: ***Address:*** ***No.:*** ( ) -

INSURANCE INFORMATION

Please select on of the following: ☐Insurance ☐Worker's Comp ☐Attorney ☐Self-Pay

If this is accident related: ACCIDENT DATE: ____/____/____

Responsible Party: **Birth Date:** - - **Address (if different)** **Home Phone No:** ( ) -

Primary Insurance Company: **Policy Number**:

☐ Primary ☐ Secondary ☐Tertiary (third Insurance) ____________________

Responsible Party's Social Security #: **Group Number:**

Patient's Relationship to Responsible party: ☐Self ☐Spouse ☐Child Other__________

Secondary Insurance Company:(if you have one) **Policy Number:**

☐ Primary ☐ Secondary ☐Tertiary (third Insurance)____________________

Responsible Party: **Social Security #:** **Birth Date:** **Group Number:**

Patient's Relationship to Responsible party: ☐Self ☐Spouse ☐Child Other__________

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address) Relationship to Patient:

Home Phone #: ( ) Work Phone #:( )

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

Patient/Guardian Signature:______________________________ ***Date***:______________