

Surgical Associates of the Cascades LLP

Patient Registration Form

(PLEASE PRINT)

RESPONSIBLE PARTY (PARENT OR GUARDIAN)					
Name - Last, First, Initial			Home Phone ()		
			Work Phone ()		
Mailing Address		City	State	Zip	CELL Phone: ()
Birth Date / /	___ Male	Social Security Number		Married / Single / Other Spouse Name:	
	___ Female				
Employer Name			Employer Address, City & State		

PATIENT INFORMATION (IF DIFFERENT FROM RESPONSIBLE PARTY)					
Patient Name - Last, First, Initial			Home Phone ()		
			Work Phone ()		
Address			City	State	
Birth Date / /	___ Male	Social Security Number		Occupation	
	___ Female				
Employer Name			Family Physician:		
Employer Address, City & State			First Visit to the clinic? Yes No		
For new patients only: How did you hear about us? <input type="checkbox"/> Physician Referral <input type="checkbox"/> Friend/Family Member/Patient <input type="checkbox"/> Advertisement (what source?: _____) <input type="checkbox"/> Provider Directory <input type="checkbox"/> Other: _____					

Health Insurance Information (Copy of card needed)		
1st Insurance	Policy Number	Group Number
Subscriber's Name	Subscriber's Birthdate	Relationship to Patient
2nd Insurance	Policy Number	Group Number7
Subscriber's Name	Subscriber's Birthdate	Relationship to Patient

Emergency Contact Information			
Relative or friends name:	Relationship:	Hm Phone:	Wk Phone:
Address, City & State:			

<u>Financial Agreement</u>	
I, the undersigned, <input type="checkbox"/> have insurance coverage, <input type="checkbox"/> do not have insurance coverage and authorize direct payment to Surgical Associates of the Cascades LLP. I acknowledge that I am financially responsible for all charges, whether or not paid by my insurance. IF IT BECOMES NECESSARY FOR THIRD PARTY COLLECTION, THE UNDERSIGNED AGREES TO PAY FOR ALL COSTS AND EXPENSES INCLUDING REASONABLE ATTORNEY FEES.	
SIGNATURE: _____	DATE _____