PATIENT REGISTRATION
PLEASE PRINT & COMPLETE ALL PORTIONS

Chart No. ______________________________

Today's Date Mo. ________ **Day** _______ **Year**_______

PATIENT NAME: ______________________________ SEX: ______ DATE OF BIRTH: ______________ AGE: _____________

MAILING ADDRESS: ______________________________ HOME TELEPHONE______________________________
Street or Box Number City State Zip

DRIVER'S LICENSE #: ______________________________ CELL #______________________________

SOCIAL SECURITY #:______________________________ E-MAIL: ______________________________

MARITAL STATUS: (check one) ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ ______________________________

PATIENT'S EMPLOYER: ______________________________ OCCUPATION: ______________________________

EMPLOYMENT STATUS: (check one) ❑ Full Time ❑ Part Time ❑ Self Employed ❑ Not Employed ❑ Retired ❑ Active Military ❑ Full Time Student ❑ Part Time Student

EMPLOYER'S ADDRESS:______________________________ EMPLOYER'S PHONE: __________________
Street or Box Number City State Zip

PRIMARY INSURANCE ______________________________ POLICY or GROUP NO. ______________________ I.D. NO. ______________________

PRIMARY INSURANCE ADDRESS: ______________________________
Street or Box Number City State Zip

SUBSCRIBER NAME:______________________________ DATE OF BIRTH: ____________________

SECONDARY INSURANCE: ______________________________ POLICY or GROUP NO.: ____________________ I.D. NO.: ________________________

SUBSCRIBER NAME:______________________________ DATE OF BIRTH: ____________________

GUARANTOR/GUARDIAN: ______________________________ DATE OF BIRTH: _______________ SS #: ____________________

ADDRESS:______________________________ HOME PHONE: ______________________________

GUARANTOR/GUARDIAN EMPLOYER: ______________________________ EMPLOYER'S PHONE: _________________OCCUPATION _______________

ADDRESS: ______________________________
Street or Box Number City State Zip

INJURY: ❑ Yes ❑ No If yes, complete the following:

DATE OF INJURY: ___________________ WHERE? ______________________________

HOW DID IT HAPPEN? ______________________________

____

Did injury occur on-the-job? ☐ Yes ☐ No Claim No: _______________________ Adjuster Name: ______________________________

EMPLOYER AT TIME OF INJURY: ______________________________

EMPLOYER'S WORKER'S COMPENSATION INSURANCE CARRIER: ______________________________

ADDRESS COMPENSATION INSURANCE CARRIER: ______________________________
Street or Box Number City State Zip

IN CASE OF EMERGENCY

CONTACT: ______________________________ RELATIONSHIP_____________________ TELEPHONE_________________

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY and ATTESTATION OF ACCURACY OF INFORMATION
I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional and medical services rendered. I have read all of the information on both sides of this registration form and have provided the above information. I certify this information is true and correct to the best of my knowledge. I will notify you immediately of any changes in my status or the above information.
Please, review and sign the reverse of this form.

Patient/Legally Authorized Representative Signature: ______________________________ Date: _________________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

For the professional or medical expense benefit allowable, and otherwise payable to me under my current and future insurance policy as payment toward the total charges for the professional services rendered; I hereby instruct and direct my Insurance Company, current and future, to pay by check made payable to Apogee Outpatient Surgery Center.
If my policy prohibits direct payment to my physician, I also direct and instruct my Insurance Company, current and future, to pay by check made payable to me. In both instances the check and explanation of benefits is to be mailed to:

Apogee Outpatient Surgery Center
PO Box 991950
Redding, CA 96009

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

I AUTHORIZE APOGEE OUTPATIENT SURGERY CENTER TO DEPOSIT CHECKS RECEIVED ON MY ACCOUNT FOR PROFESSIONAL AND MEDICAL SERVICE CHARGES WHEN MADE PAYABLE TO ME.

I agree to pay, in a current manner, any balance of said professional and medical service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize the release of any information pertinent to my case, as defined by Apogee Outpatient Surgery Center's Notice of Privacy Practices, to any insurance company, adjuster, or attorney involved in this case.

I also authorize my physician to initiate a complaint on my behalf to the Insurance Commissioner for any reason related to the adjudication of professional and medical service charges I received.

____
Signature of Policyholder

____
Signature of Witness

____
Date

____
Date

____
Signature of Claimant, if other than Policyholder

____
Date