PATIENT REGISTRATION SHEET

Patient Last Name _____ First _____ Middle _____

Address _____ City _____ State _____ Zip Code _____

M F
Sex _____ Social Security Number _____ Date of Birth _____

(_____) _____ (_____) _____
Home Phone _____ Work Phone _____ Employer Name _____

(_____) _____
Cell Phone _____ Pager or Other Phone Number _____

Insurance Company Name _____ Subscriber's Name *(Whose name is the insurance in?)* _____

Subscriber Date of Birth _____ Subscriber Social Security Number _____

M F self spouse child other _____.
Subscriber Sex _____ Patient Relationship to Subscriber (The patient is the subscriber's…….)

_____ (_____) _____
Subscriber's Employer _____ Employer Phone Number _____

_____ (_____) _____
Spouse or Parent Name _____ Relationship to Patient _____ Phone Number _____

_____ (_____) _____
Emergency Contact Name _____ Relationship to Patient _____ Phone Number _____
(Other than listed above)

I hereby assign payment directly to the surgery center all surgical and or medical benefits otherwise payable to me for its services but not to exceed its charges. Any unpaid deductible and or estimated co-pay is due and payable the day of the surgery. I understand that charges not payable by insurance is my responsibility and all charges are due in full within 90 days from the date of surgery regardless of any insurance pending.

I also authorize the surgery center to release information (to include information regarding communicable or veneral diseases) acquired in the course of examination or treatment to my insurance company, peer review or hospital if transferred for follow up care.

_____
PATIENT OR AUTHORIZED PERSON SIGNATURE Date _____

TULLAHOMA SURGERY CENTER

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Tullahoma, TN 37388
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Fax: (931) 455-7122

Form 37 (Rev. 6-04) GBF Co. 967-3533