Patient Registration Form

Patient's Legal Name: Last ______________________ First ______________________ Middle ______________
S.S.# ______________________ ☐ Female ☐ Male D.O.B. ______________________ Age __________
Marital Status ☐ M ☐ S ☐ D ☐ W Personal E-mail ______________________ Work E-mail ______________________
Home Address ______________________ City ______________________ State __________ Zip __________
Home Phone ______________ Work Phone ______________ Cell Phone ______________ Appointment Reminder ____ Text ____ Call
Occupation (or none, student, homemaker, retired) ______________________ Employer ______________________

We are required to ask the following questions due to the American Recovery and Reinvestment Act of 2009 (ARRA)
Race: ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Hawaiian or Other Pacific Islander ☐ Other ☐ White
Preferred Language: ☐ English ☐ Other ______________________
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Spouse's Name ______________________ D.O.B. ______________________ S.S.# ______________________
Employer ______________ Occupation ______________ Phone ______________ Insured Yes_______ No ______

Whom May We Contact in Case of Emergency? ____
Relationship ______________________ Phone 1 ______________________ Phone 2 ______________________

If patient is under the age of 18 years of age:
Guarantor/Insured_______________________________Patient's Legal Guardian_______________________________

Father's Name ______________________ D.O.B. ______________ S.S.# ______________
Father's Home Address ______________________ City/State/Zip ______________ Phone ______________
Father's Employer ______________ Occupation ______________ Work Phone ______________
Mother's Name ______________________ D.O.B. ______________ S.S.# ______________
Mother's Home Address ______________________ City/State/Zip ______________ Phone ______________
Mother's Employer ______________ Occupation ______________ Work Phone ______________

PLEASE READ AND SIGN THE FOLLOWING:
I directly assign all medical/surgical benefits to Idaho Surgical and/or Surgery Center of Idaho, LLC and understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize Idaho Surgical and/or Surgery Center of Idaho, LLC to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Sign here: ______________________________________ Date: ______________________

I acknowledge receipt of a copy of Idaho Surgical and/or Surgery Center of Idaho, LLC's Notice of Privacy Practice. A copy will be available at our office.

Sign here: ______________________________________ Date: ______________________

I acknowledge receipt of the Patient Financial Policy for Idaho Surgical and the Surgery Center of Idaho.

Sign here:______________________________________ **Date:**______________________