



## 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 \_\_\_\_\_  
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. \_\_\_\_\_  
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, LLC and ***understand that I am financially responsible for all charges, whether or not paid by insurance.*** I hereby authorize Idaho Surgical, 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, 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, LLC.

Sign here: \_\_\_\_\_ Date: \_\_\_\_\_