DOCTORS COMMUNITY HOSPITAL

REGISTRATION FORM
Doctors Community Surgical Associates

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name: First: Middle: ❑Mr. ❑Miss ❑Mrs. ❑Ms. Marital status (circle one) Single / Mar / Div / Sep / Wid

Social security number: Home phone number: Cell number: Birth date: / / Age: Sex: ❑M ❑F

Email address:

Street address:

P.O box: City: State: Zip code:

Occupation: Employer: Work phone number: ( )

Referring provider name: Address:

Primary physician name: Address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: Birth date: / / Address (if different): Home phone no.: ( )

Name of Insurance Subscribers name: Subscriber's social security number:

Policy number: Group number: Subscriber's DOB: / / Copay amount: $

Patient's relationship to subscriber: ❑Self ❑Spouse ❑Child ❑Other

Name of secondary insurance (if applicable): Subscriber's name: Group number: Policy number:

Patient's relationship to subscriber: ❑Self ❑Spouse ❑Child ❑Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): Relationship to patient: Home phone number: ( ) Work phone number: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Doctors Community Surgical Associates or the insurance company to release any information required to process my claims.

Patient's or guardian's signature *Date*