



SOUTHEASTERN SURGICAL
ASSOCIATES

PATIENT REGISTRATION

Patient Name _____ Sex _____

Date of Birth _____ Social Security # _____ Referring Patient or Physician _____

Street Address/Apt # _____

City _____ State _____ Zip _____

Home Telephone _____ Work Telephone _____

Employer _____

Employer's Address _____

City _____ State _____ Zip _____

Marital Status _____ Reason for Visit _____

IF DIFFERENT - PLEASE COMPLETE

Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Home Telephone _____ Work Telephone _____

Date of Birth _____ Social Security # _____

Employer _____

Employer's Address _____

City _____ State _____ Zip _____

IF DIFFERENT FROM GUARANTOR - PLEASE COMPLETE

Name _____ Relationship _____

Telephone _____ Employer _____

Workers Compensation? Yes No

Primary Insurance _____ Subscriber DOB _____

Subscriber's Name _____ Policy # _____

Mailing Address _____ Group # _____

City _____ State _____ Zip _____ Telephone _____

Secondary Insurance _____ Subscriber DOB _____

Subscriber's Name _____ Policy # _____

Mailing Address _____ Group # _____

City _____ State _____ Zip _____ Telephone _____

PATIENT
INFORMATION

GUARANTOR'S
INFORMATION

LOCAL
EMERGENCY
CONTACT

INSURANCE
INFORMATION

ASSIGNMENT & RELEASE: I certify that this information is true and correct. I hereby authorize treatment of the above-mentioned patient. I further authorize the release of medical information to any company insuring said patient and assign benefits from any medical insurance to Southeastern Surgical Associates. The undersigned patient and/or guarantor agree(s) to be responsible for payment of all charges for treatment and professional services rendered.

If this account requires collection action to secure payment, the legal fees incurred are the responsibility of the patient and/or responsible parties, as well as 33 1/3% attorney's fees.

Signature _____ Spouse's Signature _____ Date _____