Southern Surgical Associates, P.A.

Patient Registration Form

Last Name	First Name	MI	SSN

Date of Birth	Gender [ ] M [ ] F	Referring Physician	Email Address

Mailing Address	City	State	Zip

Home Phone	Cell Phone	Employer	Work Phone (May we call you at work? Yes / No)

Emergency Contact	Relationship	Phone

Do you have Medicare Part A or B?

Insurance Information

Primary	Secondary
Insurance Company Name	Insurance Company Name
Policy Holder's Name	Policy Holder's Name
Policy Holder's Social Security Number	Policy Holder's Social Security Number
Policy Holder's Date of Birth	Policy Holder's Date of Birth
Policy Number	Policy Number
Group Number	Group Number

I hereby authorize my insurance benefits to be paid directly to Southern Surgical Associates, P.A. realizing that I am responsible to pay non-covered services. I also authorize the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations. I hereby give consent to healthcare providers of Southern Surgical Associates, P.A. to evaluate and render medical treatment.

Patient Signature ______________________ Date ______________

Privacy Practice Acknowledgement

I have received the Notice of Privacy Practices and have been provided an opportunity to review it.

Patient Name ______________________ Date of Birth ______________

Patient Signature ______________________ Date ______________ Relationship ______________

For Office Use Only

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How did you hear about Southern Surgical Associates, P.A.?