# SURGERY NOW REGISTRATION FORM

(Please Print)

| Today's date: | PCP: |
|---|---|

## PATIENT INFORMATION

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

| Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ❑ M ❑ F |
|---|---|---|---|---|---|

| Street address: | Social Security no.: | Home phone no.: ( ) |
|---|---|---|

| City: | State: | Zip Code: | Email: |
|---|---|---|---|

| Occupation: | Employer: | Employer phone no.: ( ) |
|---|---|---|

Referred by: ❑ Dr. ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend

❑ Close to home/work ❑ Internet ❑ Other _____

## INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

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

| Occupation: | Employer: | Employer address: | Employer phone no.: ( ) |
|---|---|---|---|

Is this patient covered by ❑ Yes ❑ No insurance?

Please indicate Dental insurance

| Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no.: |
|---|---|---|---|---|

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

Name of Medical insurance:

| Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no.: |
|---|---|---|---|---|

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 no.: ( ) | Work phone no.: ( ) |
|---|---|---|---|

## PATIENT AUTHORIZATION

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 or deductible. I also authorize Surgery Now or insurance company to release any information required to process my claims. I authorize Dr. Husain Ali Khani and/or staff to perform an oral maxillofacial exam and take any x-rays required for this exam. I acknowledge that a copy of the Notice of Privacy Practices has been made available to me and all questions have been answered regarding this notice.

_____ _____

*Patient/Guardian signature* *Date*