Klamath Surgery Center
REGISTRATION FORM

(Please Print)

Today's date:	Primary Care Provider:

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

Ethnicity: ❒ Hispanic ❒Non Hispanic or Latino	Race: ❒Asian ❒Black or African American ❒American Indian/Alaskan ❒Native HI or Other Pacific Islander ❒Caucasian

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

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Work Related injury? ❑Yes ❑No Auto Accident ❑Yes ❑No Date of injury _____
Are you off of work due to this injury? ❑Yes ❑ No Date last worked _____

Chose center because/Referred to center by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

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

Is this person a patient here? ❑ Yes ❑ No

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

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance	❑ Medicare	❑ PHP	❑Blue Cross	❑ Pacific Source	❑ Lifewise

❑ Atrio	❑ First Health	❑ ODS	❑ OHP *(Please provide card)*	❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

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

Name of secondary insurance (if applicable):	Subscriber's name:	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.: ( )

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

Patient/Guardian signature *Date*