

## Patient Registration Form



502 Centennial Blvd., Suite 1  
Voorhees, NJ 08043  
856-874-0790 Fax: 856-874-0794

Date of Procedure: \_\_\_\_\_ Treating Physician: \_\_\_\_\_ Family Phys.: \_\_\_\_\_

Have you been here before? If yes, when? \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Street Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

Marital Status: S M D W Name of Spouse: \_\_\_\_\_

Name of Patient's Employer: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Emergency contact other than spouse: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone#: \_\_\_\_\_

Race: (check one) Asian Afro American Caucasian Hispanic Other

### INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:		SECONDARY INSURANCE COMPANY (if applicable):			
PRIMARY ADDRESS:		SECONDARY ADDRESS:			
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
PRIMARY INSURED'S NAME		SECONDARY INSURED'S NAME			
PATIENT'S RELATIONSHIP TO INSURED	SUBSCRIBER DATE OF BIRTH	PATIENT'S RELATIONSHIP TO INSURED	SUBSCRIBER DATE OF BIRTH		
PRIMARY GROUP NAME	GROUP NO.	SECONDARY GROUP NAME	GROUP NO.		
PRIMARY INSURED'S ID NO.		SECONDARY INSURED'S ID NO.			

Please bring your current insurance cards, photo ID and any referrals your insurance company may require with you. Failure to do so may cause your procedure to be rescheduled for another time.

### REFERRALS ARE THE RESPONSIBILITY OF THE PATIENT

**ASSIGNMENT & RELEASE:** I hereby assign payment directly to Centennial all surgical/medical Benefits otherwise payable to me for my services. Any unpaid deductible/co-pay/co-ins is due and payable the day of surgery. I understand that charges not paid by insurance are my responsibility and due in full with 90 days from the date of surgery regardless of any insurance pending. I understand that I am responsible for any accumulated interest fees and/or collection fees that result from this bill not being paid within 90 days. I also authorize the surgery center to release information (to include information regarding communicable or venereal diseases) acquired in the course of examination or treatment to my insurance company peer review or hospital if transferred for follow-up care. I am aware that the patient's Bill of Rights is available to me upon request.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

Parent/guardian if patient is a minor

# Medical History Questionnaire

Please print and fax or use email button at bottom of form



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Procedure Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Patient Phone (Daytime) \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Home: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Family Physician Name: \_\_\_\_\_

Are you allergic to any medications? Yes No :If yes please list: \_\_\_\_\_

Are you allergic to latex? Yes No :If yes please list: \_\_\_\_\_

Are you allergic to any foods? Yes No :If yes please list: \_\_\_\_\_

This information will be reviewed by our nurses and anesthesia staff so that we can better care for you.

**Medications:** If you take any medications or dietary supplements regularly, please complete the form below. Additional space on the bottom of form.

Medications/Supplements	Dosage	Number of Times per Day

**ASPIRIN:** Y N LAST DOSE: \_\_\_\_\_

**ANTICOAGULANTS:** Y N LAST DOSE: \_\_\_\_\_

**Last Menstrual Period:** \_\_\_\_\_

Have you ever had a surgical procedure before? Y N

If yes, Please list type of surgery and date (year)

\_\_\_\_\_

\_\_\_\_\_

Were there any anesthesia complications? Y N Describe: \_\_\_\_\_

Has anyone in your family had a severe reaction to anesthesia? Y N

**Medical History:** Please check any of the following medical conditions that you are being treated for:

Anemia	Heart Attack	Circulation Problem
Asthma/Breathing/Sleep Apnea	Heart Disease	Thyroid Disease
Cancer	Hepatitis	Psychological/Anxiety
Stroke	HIV/AIDS	Seizures
Diabetes	High Blood Pressure	Tuberculosis
GI Problem	Kidney/Bladder Problem	Prosthesis Implants, Valves
Hearing Impairment	Orthopedic Problem	Other:

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Do you smoke? Y N Number of packs per day: \_\_\_\_\_

Any history of substance abuse? Y N Do you drink alcohol? Y N If yes, how frequently/how much? \_\_\_\_\_

Do you have a Living Will or Advanced Directive?

Y N \_\_\_\_\_

Is there anything in your religious or cultural belief that would affect your care?

Y N \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Reviewed Front & Back by:** \_\_\_\_\_ **Date:** \_\_\_\_\_

