

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: (circle one) Asian Afro American Caucasian Hispanic Other

INSURANCE INFORMATION					
PRIMARY INSURANCE			SECONDARY INSURANCE		
INSURANCE BILLING ADDRESS			INSURANCE BILLING ADDRESS		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE
INSURED'S NAME			INSURED'S NAME		
PATIENT'S RELATIONSHIP TO INSURED		SUBSCRIBER DATE OF BIRTH	PATIENT'S RELATIONSHIP TO INSURED		SUBSCRIBER DATE OF BIRTH
GROUP NAME		GROUP NO.	GROUP NAME		GROUP NO.
INSURED'S ID NO.			INSURED'S ID NO.		

***REFERRALS ARE THE RESPONSIBILITY OF THE PATIENT.**
***If no referral is received it may be necessary to reschedule the procedure.**

ASSIGNMENT & RELEASE: I request that payment of authorized insurance benefits on my behalf are made to Centennial Surgery Center for any services or supplies furnished me by the facility. I authorize any holder of medical information about me to release to my insurance carrier or its' agents any information needed to determine these benefits or the benefits payable for related services. I authorize you to give me reasonable and proper medical care, including diagnosis and treatment (medical and surgical) by today's standards. I am aware that a copy of the Patient's Bill of Rights is available to me upon request.

I am financially responsible for charges not paid by insurance and attest that the information above is correct.

SIGNED: _____ DATE: _____

Parent/Guardian if Patient is a Minor