Suffolk Surgery Center

Private Insurance Registration Form

This form should be completed prior to your appointment at Suffolk Surgery Center and brought with you at your appointment. The form can be filled out on screen and then printed out or printed out first and then completed by hand.

PATIENT INFORMATION

First Name:	Middle Initial:	Last Name:	
Social Security #:	Date of Birth:	Age:	Sex: Male ☐ Female ☐
Home Phone:	Cell Phone:	Work Phone:	
Home Address:	City:	State:	Zip Code:
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Race: ☐ African American ☐ Caucasian ☐ Hispanic ☐ Other Nationality:		
Employer:	Employed: ☐ Full Time ☐ Part-Time ☐ Retired		
Email Address:	Person to Notify in Case of Emergency	Relationship:	

Primary Insurance Plan

Who is the primary person on the primary insurance plan? ☐ It is my plan ☐ My husband's/wife's plan ☐ Someone Else

Primary Insured's Information:

Last Name:	First Name:		Middle Initial:
Social Security #:	Date of Birth:	Age:	Sex: Male ☐ Female ☐

INSURANCE DETAILS:

My plan is: ☐ PPO ☐ POS ☐ HMO ☐ Medicare ☐ Medicaid/HMO Other:_____

Insurance Company/Tel#: _____ Address _____

Member ID#_____ Group ID #_____

Secondary Insurance Plan

Who is the primary person on the secondary insurance plan? ☐ It is my plan ☐ My husband's/wife's plan ☐ Someone Else

Primary Insured's Information:

Last Name:	First Name:		Middle Initial:
Social Security #:	Date of Birth:	Age:	Sex: Male ☐ Female ☐

INSURANCE DETAILS:

My plan is a ☐ PPO ☐ POS ☐ HMO ☐ Medicare ☐ Medicaid/Medicaid HMO Other:_____

Insurance Company/Tel #:_____ Address _____

Member ID#_____ Group ID #_____

Authorization for Assignment of Benefits/ Information Release

I herby assign to and authorize payment directly to Suffolk Surgery Center all benefits payable under the terms of any insurance policy. I realize the insurance benefits may not pay the entire bill(s) and I agree to pay the difference or the entire bill if necessary. I authorize the release of any medical information necessary to process claims on any insurance policy listed above or provided separately. This information will be used for the purpose of evaluating and administering claims or benefits.

Patient/ Guardian Signature (If child is under 18yrs old) _____ Date:_____