Suffolk Surgery Center

Registration Form for Workman's Compensation and No Fault Insurance

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		
PATIENT'S NAME	Surgeon Name	
STREET ADDRESS APT.#	SOCIAL SECURITY #	DATE OF BIRTH
CITY STATE ZIP CODE	HOME #	SEX M ☐ F ☐
PATIENT'S EMPLOYER	CELL #	MARITAL STATUS S ☐ M ☐ W ☐ D ☐
EMPLOYER'S ADDRESS	WORK #	WORK EXT:
CITY STATE ZIP	RACE: AA ☐ C ☐ H ☐ OTHER ☐	NATIONALITY:

WORKERS COMP INFORMATION		
WC. CARRIER NAME:	PERSON HANDLING CASE	ACCIDENT DATE
STREET ADDRESS	PHONE NO.	DO YOU HAVE MORE THAN ONE CASE? YES ☐ NO ☐
CITY STATE ZIP	ID #/ FILE #	BODY AREA INJURED

NO- FAULT INFORMATION		
NF CARRIER NAME:	PERSON HANDLING CASE	ACCIDENT DATE
STREET ADDRESS	PHONE NO.	EXT.
CITY STATE ZIP	CASE # / FILE #	BODY AREA INJURED
NAME OF POLICY HOLDER	POLICY #	DO YOU HAVE MORE THAN ONE CASE? YES ☐ NO ☐

MAJOR MEDICAL INSURANCE		
CARRIER NAME:	INSURED NAME:	Self ☐ Spouse ☐ Parent ☐
INSURANCE ADDRESS	GROUP #	DATE OF BIRTH
CITY STATE ZIP	PHONE NO.	

AUTHORIZATION INFORMATION	
AUTHORIZATION TO RELEASE MEDICAL INFORMATION I authorize the release of medical pertaining to my history, services rendered, or treatment given to me, or my dependents for purposes of review of this claim. Signature: _____ Date: _____	ASSIGNMENT AUTHORIZATION I understand if my No-Fault/Workers Compensation insurance denies payment for services that have been rendered to me, I will be financially liable for those services. In the event that my No-Fault/ Workers Compensation insurance denies paying my claim, I authorized Suffolk Surgery Center, to bill my major medial carrier for those services. I agree that if my major medical carrier refuses to pay for those services I will continue to be financially liable for the unpaid balances. Signature: _____ Date: _____