PRIVATE INSURANCE REGISTRATION SHEET

Patient Information

First Name	Middle Initial	Last Name	
Social Security #	Date of Birth	Age	Gender ☐ Male ☐ Female
Home # ( )	Cell # ( )	Work # ( )	
Home Address	City	State	Zip Code
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed		Race ☐ African American ☐ Caucasian ☐ Hispanic ☐ Other Nationality:	
Employer		Employment Status ☐ Full Time ☐ Part Time ☐ Retired	
Email Address	Emergency Contact Name	Emergency Contact Phone #	

Primary Insurance Plan

Who is the primary person on the primary insurance plan?

☐ Myself ☐ My spouse ☐ Someone else

Primary Insured's Information:

Last Name	First Name	Middle Initial
Social Security #	Date of Birth / /	Age	Gender ☐ 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 primary insurance plan?

☐ Myself ☐ My spouse ☐ Someone else

Primary Insured's Information:

Last Name	First Name	Middle Initial
Social Security #	Date of Birth / /	Age	Gender ☐ Male ☐ Female

Insurance Details:

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

Insurance Company/Tel#: _____ Address: _____

Member ID # Group ID #

Authorization for Assignment of Benefits/Information Release

I hereby 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 listed above or provided separately. This information will be used for the purpose of evaluating and administering claims or benefits.

Patient/Guardian Signature **X** **Date:**