WC/NF PATIENT REGISTRATION SHEET

Patient Information		
Patients Name	Surgeon Name	
Street Address Apt. #	Social Security #	Date of Birth
City, State, Zip Code	Home # ( )	Gender Male Female
Patient's Employer	Cell # ( )	Marital Status S M W D
Employers Street Address	Work # ( )	Work Extension
Employer City, State, Zip Code	Race AA C H Other	Nationality

Workers Comp Information		
WC Carrier Name	Person Handling Case	Accident Date
Street Address	Phone Number ( )	Do you have more than one case? YES NO
City, State, Zip Code	ID # / File #	Body Area Injured

No-Fault Information		
NF Carrier Name	Person Handling Case	Accident Date
Street Address	Phone Number ( )	Extension
City, State, Zip Code	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: (CIRCLE ONE) Self Spouse Parent	
Insurance Address	Group #	Date of Birth
City, State, Zip Code	Phone Number ( )	

Authorization Information

AUTHORIZATION TO RELEASE MEDICAL INFORMATION	ASSIGNMENT AUTHORIZATION
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:	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 authorize Suffolk Surgery Center, to bill my major medical 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 balance. Signature: Date::