Arizona Community Surgeons
dba
Southwestern Surgery Associates

PATIENT REGISTRATION FORM

How did you hear about us? _____ Date _____

PATIENT INFORMATION

Name _____
Last First Nickname MI
Address _____
Street City State Zip
Phone w/ area code _____ Work phone_____ Cell _____
Social Security Number _____ Birthdate _____
Sex: Δ Female Δ Male Marital Status: Δ Single Δ Married Δ Divorced Δ Separated Δ Widowed
If married, spouse's name _____
Nearest relative OTHER than spouse _____
Relationship _____ Phone number _____
Primary Care Physician _____ Referring Physician _____
Employer _____ Occupation _____
Employer's Address _____
Person responsible for bill, if other than patient _____
Social Security of responsible person _____
Employer of responsible person _____ Phone number_____

INSURANCE INFORMATION – PLEASE GIVE YOUR CARDS TO RECEPTIONIST FOR SCANNING

Primary Insurance _____
Insured's Name _____ Birth Date _____
Through Employer? Δ Yes Δ No ID Number _____ Group Number_____
Secondary Insurance _____
Insured's Name _____ Birth Date_____
Through Employer? Δ Yes Δ No ID Number _____ Group Number_____
Do you have AHCCCS? Δ Yes Δ No
Is this visit due to an injury on the job? Δ Yes Δ No Date of injury _____
Employer at the time of injury _____

ALL PATIENTS PLEASE COMPLETE AND SIGN THIS RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS:
"I hereby authorize Southwestern Surgery Associates, LTD to release to or request from my insurance company, other physicians or hospitals, any information including the diagnosis and records or any treatment or examination rendered to me during surgical care, and that this information my be faxed. I also authorize and request my insurance companies to pay directly to the above-named corporation the amount due me in my pending claim for medical and/or surgical treatment or service. I also understand that if it becomes necessary to refer my account for collection, I will be liable for the reasonable collection fees and court costs expended herein." THE PHYSICIANS RESERVE THE RIGHT TO CHARGE INTEREST ON UNPAID ACCOUNTS.

Patient's Signature _____ Date _____
(or Parent/Guardian if patient is a minor)

"Duplicate of this release & assignment is as valid as the original"