

# PRINCETON SURGICAL ASSOCIATES REGISTRATION FORM

Date of Birth \_\_\_\_\_

Name \_\_\_\_\_  
Last Name First Name Initial Soc. Sec. # \_\_\_\_\_

Address \_\_\_\_\_  
Home Phone # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Cell# \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Work Phone# \_\_\_\_\_

Sex: \_\_\_ M \_\_\_ F Is this visit due to an injury? \_\_\_ Yes \_\_\_ No.

Marital Status: \_\_\_ S \_\_\_ M \_\_\_ W \_\_\_ D Is it related to a motor vehicle accident? \_\_\_ Yes \_\_\_ No.

Is it work related? \_\_\_ Yes \_\_\_ No.

Referring Physician \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

Phone# \_\_\_\_\_ Phone# \_\_\_\_\_

Person to be Contacted \_\_\_\_\_ Relationship \_\_\_\_\_  
In Case of Emergency \_\_\_\_\_ To Patient \_\_\_\_\_ Phone# \_\_\_\_\_

*(please include contact on HIPAA form)*

## PRIMARY INSURANCE

Insured's Name \_\_\_\_\_ Insured's Birth Date \_\_\_\_\_ Relationship To Patient \_\_\_\_\_

Soc. Sec. # of Insured \_\_\_\_\_ Insured's Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_ Identification Number \_\_\_\_\_ Group Number \_\_\_\_\_

Address: \_\_\_\_\_ Phone# \_\_\_\_\_

## SECONDARY INSURANCE

Insured's Name \_\_\_\_\_ Insured's Birth Date \_\_\_\_\_ Relationship To Patient \_\_\_\_\_

Soc. Sec. # of Insured \_\_\_\_\_ Insured's Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_ Identification Number \_\_\_\_\_ Group Number \_\_\_\_\_

Address: \_\_\_\_\_ Phone# \_\_\_\_\_

## ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with \_\_\_\_\_.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the physician to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions:

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_