Watauga Surgical Group, P.A.

PATIENT REGISTRATION FORM

PLEASE PRINT PLAINLY AND COMPLETE EACH LINE

Date________________________________

First Name__________________________Middle ______________________Last ____________________________

Mailing Address____Apt #_____________

(If PO Box, please list 911 address)____

City ____ State ____________ Zip _____________________

Home Telephone (________)_________-__________ Work (________)________-__________

Cellphone (________)________-____________

***Secondary Mailing Address____Apt #___________

(If PO Box, please list 911 address)____

City ____ State ________________ Zip ___________________

Date-of-Birth ____________________ Age______ Sex: □ Male □ Female

Social Security Number: _____________________________ Drivers License # _________________ State ______

Employer Name: ____

Employer Address: ____ State ________ Zip _________

Marital Status: □ Married □ Single □ Divorced □ Widowed (Check one)

Race (please check one)

□ White □ Hispanic □ Black or African American □ Asian □ American Indian or Alaska Native □ Other □ Undetermined

Ethnicity (please check one)

□ Non Hispanic or Non Latino □ Hispanic or Latino □ Other □ Undetermined

Preferred Language (please check one)

□ English □ Spanish

SPOUSE- PARENT (if minor) INFORMATION

Name____ Date of Birth_________________

Social Security Number______________________ Cell phone # (______)_____-__________

Employer____Employer Phone (______)_______ - ______________

EMERGENCY CONTACT

Name____ Relationship to You_____________________

Address____
Street City/State Zip

Telephone (_________) __________-________________ Cell phone (________) _________-_____________

MEDICAL INSURANCE *Please provide insurance cards*

PRIMARY (Name of Insurance) ____

Insured's Name ___________________________________ Insured's DOB: ______________

Insured's SS# _________________________ Relationship to Insured: □Self □ Spouse □ Child □ Other (Check one)

SECONDARY (Name of Insurance) ____

Insured's Name ___________________________________ Insured's DOB: __________________

Insured's SS# _________________________ Relationship to Insured: □ Self □ Spouse □ Child □ Other (Check one)

ASSIGNMENT OF BENEFITS

I hereby authorize and direct my insurance carrier, including Medicare, to issue payment directly to Watauga Surgical Group, P.A. for medical services rendered.

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Signature