Indiana Surgical Associates P.C.

Patient Registration Form

Patient Information

Patient Information: (PLEASE FILL OUT ALL SECTIONS BELOW)

Last Name:	First Name:	M.I.:	Previous Name (if applicable)
Mailing Address:			Sex: ❑ Male ❑ Female
Home Phone:	Cell Phone:	Work Phone:	
Social Security #:	Date of Birth:	Referring Physician:	Primary Physician:
Email Address:		Marital Status: ☐ Married ☐ Divorced ☐ Legally Seperated ☐ Single ☐ Widowed ☐ Partner	
Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ☐ Active Military ☐ F/T Student ☐ P/T Student		Employer Name:	
Pereferred Pharmacy & Location:	Preferred Language (please select one): ☐ English ☐ Spanish ☐ Other (please list): ☐ Sign Language ☐ Chinese		
Emergency Contact Name:	Emergency Contact Phone #:		
Emergency Contact Address:	Relationship to Patient:		

Add'l Info. and Responsible Party

Responsible Party: If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor

CHECK HERE IF INFORMATION IS SAME AS PATIENT: ☐

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:	Relationship to Patient:	

Additional Information:

Race: ☐ White ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Hispanic ☐ American Indian or Alaska Native ☐ Asian ☐ Decline to specify

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline to specify

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Insurance Co. Name	Insurance Co. Name
Policy Holder Name:	Policy Holder Name:
Policy #:	Policy #:
Group ID:	Group ID:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

Communication with Others:

W[illegible]

☐

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

☐ , I prefer that my doctor or staff speak to only myself, personally, regarding any medical information.

These communications may include information such as test results, prescription refills, appointments, instructions regarding treatments or medications, and billing information.

Message Preferences:

Please check one of the o es elo :

☐ [illegible]

☐ lease do not leave messages on my answering ma hine or voi email

Rev. 2.2018

Signature of Patient or Guardian: X _____ **Date:**