# Northern California Advanced Surgery Center, LP

## *Patient Registration*

**Please read carefully before completing form.**

We expect an insurance form completed if indicated for your insurance coverage.
We will also need copies of all insurance cards (including Medicare cards).

Patient Name: _____ Age: _____
(Last) (First) Middle)

Date of Birth: ___/___/____ Sex: ☐ Male ☐ Female Telephone: (____) _____
mm / dd / yyyy

Address: _____

City: _____ State: _____ Zip: _____

Patient's Social Security Number: _____-_____-_____ Language Preferred: _____

Employer: _____

Primary Insurance: _____ Medical Group: _____

Secondary Insurance: _____ Medical Group: _____

Third Insurance: _____ Medical Group: _____

Spouse's Name/Guarantor: _____ Guarantor's Date of Birth: _____/_____/_____

Guarantor/Spouse's Social Security Number: _____-_____-_____

Are you living in a skilled nursing facility? ☐ Yes ☐ No

Referring Physician: _____

Primary Medical Doctor: _____

In Case of Emergency—Please list nearest relative/friend we may contact (not living with you).

Name: _____ Telephone: (_____) _____

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**Insurance Authorization and Assignment**

I hereby authorize the Northern California Advanced Surgery Center, LP to furnish information to insurance carriers, and any other physicians involved in my care, regarding my illness and treatments. I hereby assign to the physician(s) all payment for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by the insurance company.

Date: _____ Signature: _____

**Workmen's Compensation Case**

*(Must be completed in full if this is a Workman's Compensation Case)*

Date of Injury: _____/_____/_____ Claim/File #: _____

Month Day Year

Patient's Social Security Number: _____-_____-_____

Employer (where injury occurred): _____

Employer's Name: _____

Address: _____ Telephone: (_____) _____

Insurance Company's Name: _____

Address: _____ Telephone: (_____) _____

Case Contact Name: _____ Telephone: (_____) _____

(Name)

**Auto Accident**

Date of Injury: _____/_____/_____

Month Day Year

Name of Auto Insurance Carrier: _____

Address: _____ Telephone: (_____) _____