Avoyelles Surgical Associates

Patient Registration

Date_____/_____/2011

Name:_____

Birth date:_____/_____/_____ AGE:_____ RACE:_____

Sex: M / F SSN#_____/_____/_____

Mailing Address: _____

_____

Home Phone#_____Work / Cell_____

Spouse Name_____ PHONE# _____

Occupation _____

Employer_____ Employers Phone #_____

Address_____

_____

Emergency Contact Person: _____

Referring by: Self Friend Dr._____

Insurance Primary_____

Secondary_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physicians. I understand that I am financially responsible for all deductibles, coinsurance, and non covered services whether or not paid by insurance. Coinsurance and deductible are based upon the charge determination of the insurance carrier. I also authorize ***Avoyelles Surgical Associates*** or insurance company to release any information required to process my claims.

_____ _____

Patient Signature Date