

REGISTRATION

(PLEASE PRINT)

Memphis Surgery Center

1044 Cresthaven Road
Memphis, TN 38119

Telephone: (901) 682-1516
Fax: (901) 682-1545

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name Last Name _____ First Name _____ Middle Initial _____	SS/HIC/Patient ID # _____
Address _____	E-mail _____
City _____	State _____ Zip _____
Sex <input type="checkbox"/> M <input type="checkbox"/> F Age _____ Birthdate _____ <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Minor <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered for _____ years	
Patient Employer/School _____	Occupation _____
Employer/School Address _____	Employer/School Phone (____) _____
Whom may we thank for referring you? _____	
In case of emergency who should be notified? _____	Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account Last Name _____ First Name _____ Middle Initial _____	
Relation to Patient _____ Birthdate _____	Soc. Sec. # _____
Address (if different from patient's) _____	Phone (____) _____
City _____	State _____ Zip _____
Person Responsible Employed by _____	Occupation _____
Business Address _____	Business Phone (____) _____
Insurance Company _____	
Contract # _____ Group # _____	Subscriber # _____
Names of other dependents covered under this plan _____	

ADDITIONAL INSURANCE

Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Subscriber Name _____ Birthdate _____	Relation to Patient _____
Address (if different from patient's) _____	Phone (____) _____
City _____	State _____ Zip _____
Subscriber Employed by _____	Business Phone (____) _____
Insurance Company _____	Soc. Sec. # _____
Contract # _____ Group # _____	Subscriber # _____
Names of other dependents covered under this plan _____	

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)
Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand
that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies)
and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.
This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient