WILLOUGHBY SURGERY CENTER DEMOGRAPHIC SHEET

Last Name:_____ First:_____ Date of Birth:_____

Age:_____ Social Sec#_____-_____-_____ Sex: M or F Home Phone: (___) _____-_____

Home Address:_____ City:_____

State:_____ Zip:_____ Marital Status: Sin Mar Div Wid Cell Phone: (___)_____-_____

Home Mailing Address (if different):_____

Employer Name:_____ Occupation:_____ Work Phone: (____)_____-_____

Employer Address:_____ Employer Phone:(____)_____-_____

Spouse's Name:_____ Spouse's Social Sec:_____-_____-_____

Emergency Contact Person:_____ Relationship:_____ Phone: (____)_____-_____

Name of Referring Doctor:_____ Phone: (____)_____-_____

Primary Care Physician:_____ Phone: (____)_____-_____

Please provide this office with a copy of your Insurance Cards at time of registration

Is this procedure related to an auto accident, work injury, or condition involving legal assistance? ____Yes ____No

If so, Type of accident: Work Injury Auto Home Other:_____ Claim#_____

If so, Date of Injury/Accident:_____/_____/_____ Fill in Insurance under Primary Insurance

Attorney's Name:_____ Phone: (____)_____-_____

Medicare Insurance #_____ Medicaid Insurance #_____

Primary Insurance Carrier Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone: (____)_____-_____ Policy #:_____ Group #:_____

Name of Person this policy is under:_____

Secondary Insurance Carrier Name:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone: (____) _____-_____ Policy #:_____ Group #:_____

Name of person this policy is under:_____

Medical Authorization/financial Assignment Agreement **(Important)**

I authorize any holder of my medical information to release this information to Willoughby Surgery Center (WSC) should they request. I authorize WSC to provide medical services for my condition, and to release any medical information about me to my insurance company. I authorize any holder for request of payments to make payment directly to WSC for services rendered. I will be responsible for any amounts not covered under my insurance plan, including co-pays, deductibles, or any charges not covered by insurance plan. If my insurance is Medicare, or any others with a contract with WSC, WSC will file all claims directly to the carrier on my behalf, and WSC will receive payment from the carrier. If my insurance is not contracted with WSC, as a courtesy, WSC will still file a claim with my insurance carrier. However, if my insurance issues a check to the policy holder for services rendered, I will endorse the check in full to WSC. If there is any outstanding debt that is eventually turned over to a collection agency, I understand that I still will be responsible for the initial debt plus any fees that the collection agency will collect regarding my account with WSC.

I have read the above statement, and understand the credit policy set forth.

Patient Signature:_____ Date:_____

Guardian Name: (print)_____ Signature:_____