

Account # <i>For internal use</i>	Outpatient Surgery Center 160 Hwy 201 North • Mtn. Home, AR 72653 • 870-508-2100	DATE _____ _____ _____	INITIAL _____ _____ _____
DATE _____ _____ _____	REGISTRATION INFORMATION		

PATIENT INFORMATION

LAST NAME	FIRST NAME	MI	BIRTHDATE	SOCIAL SECURITY #
HOME ADDRESS	CITY		STATE	ZIP
SPOUSE'S NAME	HOME #		WORK #	MARRIED STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE
EMAIL ADDRESS				<input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED

RESPONSIBLE PARTY/GUARDIAN INFORMATION

RESPONSIBLE PARTY NAME	LAST	FIRST	MI	RESPONSIBLE PARTY HOME PHONE
RESPONSIBLE PARTY ADDRESS	CITY	STATE	ZIP	RESPONSIBLE PARTY SOCIAL SECURITY #
RESPONSIBLE PARTY EMPLOYER	OCCUPATION			RESPONSIBLE PARTY WORK PHONE
RESPONSIBLE PARTY ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO RESPONSIBLE PARTY <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER
MOTHER'S NAME	MOTHER'S BIRTHDATE	FATHER'S NAME	FATHER'S BIRTHDATE	

EMPLOYMENT INFORMATION

PATIENT'S EMPLOYER OR SCHOOL NAME IF STUDENT:	OCCUPATION	EMPLOYMENT OR STUDENT STATUS:
PATIENT'S EMPLOYER'S OF SCHOOL ADDRESS		<input type="checkbox"/> FULL-TIME <input type="checkbox"/> NOT EMPLOYED <input type="checkbox"/> SELF EMPLOYED
CITY	STATE	ZIP
		<input type="checkbox"/> PART-TIME <input type="checkbox"/> RETIRED <input type="checkbox"/> ACTIVE MILITARY

EMERGENCY INFORMATION

NEXT-OF-KIN – Other than spouse	RELATIONSHIP
NEXT-OF-KIN ADDRESS	NEXT-OF-KIN PHONE
CITY	STATE
STATE	ZIP

INSURANCE INFORMATION

PRIMARY INSURANCE	SOCIAL SECURITY #	CARDHOLDER	DATE OF BIRTH
GROUP NUMBER	IDENTIFICATION NUMBER		
ADDRESS	CITY	STATE	ZIP
			PHONE
SECONDARY INSURANCE	CARDHOLDER	DATE OF BIRTH	
GROUP NUMBER	IDENTIFICATION NUMBER		
ADDRESS	CITY	STATE	ZIP
			PHONE NUMBER

ASSIGNMENT OF BENEFITS AND RECORDS RELEASE

ASSIGNMENT OF BENEFITS
 I hereby authorize direct payment to Outpatient Surgery Center, Inc., and Ambulatory Surgery Anesthesia Group, Inc., of any medical benefits payable to me for the services & anesthesia provided at Outpatient Surgery Center, Inc.
 I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to appointment. I will be responsible for the unpaid balance due any bills if this is not done.

 X _____
 Patient Signature or Signature of Guardian or Parent Date

RECORDS RELEASE
 I hereby authorize Outpatient Surgery Center, Inc., to release my records to my insurance company and/or primary care physician for the purpose of processing my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by payer.

 X _____
 Patient Signature or Signature of Guardian or Parent Date