

**PATIENT REGISTRATION AND AUTHORIZATION**

PATIENT	PATIENT NAME (LAST, FIRST, MIDDLE)				SOCIAL SECURITY NUMBER				
	DATE OF BIRTH	AGE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	LANGUAGE <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Italian <input type="checkbox"/> Japanese <input type="checkbox"/> Spanish <input type="checkbox"/> Portuguese <input type="checkbox"/> Other			MARITAL STATUS <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Life Partner <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed		
	RACE <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> White <input type="checkbox"/> Other				ETHNICITY <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino				
	ADDRESS				CITY, STATE		ZIP CODE		
	TELEPHONE		PAGER/CELL PHONE		REFERRING PHYSICIAN				
	EMPLOYER		EMPLOYER ADDRESS		CITY, STATE		ZIP CODE		
	EMPLOYER TELEPHONE		EXTENSION	PATIENT'S E-MAIL					
	GUARANTOR	RELATIONSHIP TO PATIENT		GUARANTOR NAME		SOCIAL SECURITY NUMBER		DATE OF BIRTH	AGE
ADDRESS				CITY/STATE		ZIP CODE			
TELEPHONE		PAGER/CELL PHONE		EMPLOYER					
EMPLOYER TELEPHONE									
EMERGENCY CONTACT					PHARMACY				
NAME			RELATIONSHIP TO PATIENT		NAME			Telephone	
TELEPHONE		EMPLOYER TELEPHONE	PAGER/CELL PHONE		LOCATION/ADDRESS				
PRIMARY INSURANCE					SECONDARY INSURANCE				
INSURANCE COMPANY NAME					INSURANCE COMPANY NAME				
ID#		GROUP#			ID#			GROUP#	
PATIENT'S RELATIONSHIP TO SUBSCRIBER					PATIENT'S RELATIONSHIP TO SUBSCRIBER				
SUBSCRIBER'S NAME					SUBSCRIBER'S NAME				
SUBSCRIBER'S SS#			DOB		SUBSCRIBERS SS#			DOB	

**FINANCIAL RESPONSIBILITY, AUTHORIZATION TO RELEASE INFORMATION & FINANCIAL DISCLOSURE:**

I assign to **Surgical Associates, Inc.**, any and all health insurance benefits and other public and private benefits covering the medical treatment provided to me, and I direct that all payments for such services be made directly to **Surgical Associates, Inc.** I understand that I am financially responsible for all insurance deductibles, coinsurance payments and for the cost of all medical treatment that is not covered by insurance or for which there are no other benefits available.

**Surgical Associates'** physicians have an ownership interest in *Oklahoma Surgical Hospital, LLC*, and *Sleep Solutions, LLC*, and your physician may refer you to one or more of these facilities for medical treatment. Please let your physician know if any questions about these medical facilities. By signing below, you acknowledge the disclosure of your physician's ownership interest in these medical facilities and you consent to treatment at these facilities.

I consent to the disclosure of my Protected Health Information to my health insurance provider, and to all other public and private providers of benefits, if any, for my medical treatment. I additionally consent to the disclosure of my Protected Health Information to all medical providers that are necessary for my medical treatment.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_