SA SURGICAL ASSOCIATES

Board Certified • General Surgery • Surgical Oncology • Colon & Rectal Surgery

PATIENT REGISTRATION AND AUTHORIZATION

PATIENT

PATIENT NAME (LAST, FIRST, MIDDLE)			SOCIAL SECURITY NUMBER
DATE OF BIRTH	AGE	SEX ☐ M ☐ F	LANGUAGE ☐ English ☐ French ☐ Italian ☐ Japanese ☐ Spanish ☐ Portuguese ☐ Other
MARITAL STATUS ☐ Divorced ☐ Legally Separated ☐ Life Partner ☐ Married ☐ Never Married ☐ Single ☐ Widowed			
RACE ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native ☐ Other_____			ETHNICITY ☐ Hispanic or Latino ☐ Not Hispanic or Latino
ADVANCE DIRECTIVE ☐ Yes ☐ No			
ADDRESS	CITY, STATE		ZIP CODE
TELEPHONE	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	SEX ☐ M ☐ F
ADDRESS	CITY, STATE	ZIP CODE			
TELEPHONE	CELL PHONE	EMPLOYER			
EMPLOYER TELEPHONE					

EMERGENCY CONTACT			PHARMACY	
NAME	RELATIONSHIP TO PATIENT		NAME	TELEPHONE
TELEPHONE	EMPLOYEE TELEPHONE	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	SUBSCRIBER'S 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 you have 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** _____