

# WISCONSIN SURGERYCENTER PATIENT REGISTRATION

Please print and complete all information requested on this form.

## PATIENT- This section refers to PATIENT ONLY

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
SS No. \_\_\_\_\_ Sex (Circle one) Male Female  
Marital Status (Circle one) Single Married Divorced Widowed Maiden Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

The State of Wisconsin Office of Health Care Information requires Wisconsin Surgery Center to provide them with information as to our patient's race and ethnicity. Please check the appropriate areas below.

Race: \_\_\_\_\_ American Indian or Alaskan Native \_\_\_\_\_ Asian or Pacific Islander \_\_\_\_\_ Black \_\_\_\_\_ White  
\_\_\_\_\_ Other \_\_\_\_\_ Unknown or chose not to answer  
Ethnicity: \_\_\_\_\_ Hispanic \_\_\_\_\_ Not of Hispanic Origin \_\_\_\_\_ Unknown or choose not to answer

## RESPONSIBLE PARTY- This section refers to the PERSON RESPONSIBLE FOR PAYMENT

Check which one applies: \_\_\_\_\_ Self \_\_\_\_\_ Pt is a minor. See insurance information below.

## PERSON TO CONTACT IN CASE OF EMERGENCY

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

## PRIMARY INSURANCE INFORMATION

Please check which one applies to you and complete information below. \_\_\_\_\_ Insurance \_\_\_\_\_ Workman's Comp \_\_\_\_\_ Self Pay

Insurance Company's Name & Address \_\_\_\_\_  
Insured's Name (who holds insurance) \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_ Date of Injury (REQUIRED) \_\_\_\_\_

## WORKMAN'S COMP ONLY – REQUIRED INFORMATION

Case worker's name \_\_\_\_\_ Phone \_\_\_\_\_ Claim # \_\_\_\_\_

## SECONDARY INSURANCE INFORMATION

Insurance Company's Name & Address \_\_\_\_\_  
Insured's Name (who holds insurance) \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_

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I hereby authorize Wisconsin Surgery Center, LLC to furnish my insurance carrier all information that my insurance company may request concerning my illness or injury. I hereby assign to Wisconsin Surgery Center, LLC all money to which I am entitled to for medical and surgical expense rendered to myself or dependent. I understand that I am responsible for any amount not covered by insurance. Any bill coming from Wisconsin Surgery Center are the facility charges and do not pertain to my Physician charges.

PATIENT OR GUARANTOR'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made on my behalf to Wisconsin Surgery Center for any services furnished by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. Furthermore, this authorization serve this provider to obtain benefits from my Medicare Supplemental insurer. This authorization is in effect until I choose to revoke it.

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