WISCONSIN
SURGERY CENTER

Phone: 414-384-2100
Fax: 414-384-2700

PATIENT REGISTRATION FORM

PATIENT - THIS SECTION REFERS TO PATIENT ONLY

Please print and complete all information requested on this form.

Name | Age | Date of Birth

SS No. | Sex ☐ Male ☐ Female | Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Maiden Name | Address

City | State | Zip Code

Email | 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 choose 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 ☐ Spouse/Significant Other ☐ Patient 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 Compensation ☐ Self Pay

Insurance Company' s Name and Address

Phone Number | Insured's Name (who holds insurance) | Insured's Date of Birth

Relationship to Patient

HIC/Policy Number | Group Number

WORK COMP and MVA —REQUIRED INFORMATION

Case worker' s name | Phone | Claim# | Date of Injury (REQUIRED)

SECONDARY INSURANCE INFORMATION

Insurance Company' s Name and Address

Phone Number | Insured's Name (who holds insurance) | Insured's Date of Birth

Relationship to Patient

HIC/Policy Number | Group Number

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 Came, LLC all money to which I am entitled to for medical and surgical expenses rendered to myself or dependent. I understand must I am responsible for my 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 authorised 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 payable for related services. Furthermore, this authorization serves this provider in obtain benefits from my Medicare Supplemental insurer. This authorization is in effect until I choose to revoke it.

SIGNATURE | DATE