Wright State Physicians
SURGERY

Department of Surgery
PATIENT REGISTRATION FORM

Name				**Emergency Contact** (closest relative not living with patient)	
Address					
City		State		Contact's Phone #	
Sex	❑M ❑F	Zip Code		**(First, last name of physician and specify MD or DO please)**	
DOB		Home Ph		Referring Physician	
SSN		Cell Ph		Other Involved MD's	
e-mail		Alt. Ph		Family Doctor	
				Today's appt with	

Pharmacy Name and Phone Number

How did you hear about our office? ❒ TV ❒ Radio ❒ Newspaper ❒ Magazine ❒ Friend

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Other

PRIMARY INSURANCE

Company		Policy Holder	
Policy Holder Name		SSN	
Employer		DOB	
Relation of patient to insured			

❑ **Same as patient information listed above.**

SECONDARY INSURANCE

Company		Policy Holder	
Policy Holder Name		SSN	
Employer		DOB	
Relation of patient to insured			

❑ **Same as patient information listed above.**

RESPONSIBLE PARTY **Amounts not paid by insurance company will be billed to this person.**

Name		Employer		
Address		Address		
City		City, State		
Zip Code		Zip Code		
Birthdate		Phone #		Ext.

❑ **Same as patient information listed above.**

COMMENTS and/or ANY SPECIAL NEEDS (i.e. wheelchair, stretcher, interpreter, etc.):

CONSENT TO TREAT & AUTHORIZATION FOR RELEASE OF BILLING INFORMATION
Please read completely and sign. Services may be withheld if not signed.
I recognize the need for health care and consent to services as ordered by the physician(s). I hereby authorize the release of any medical information necessary from Wright State Physicians for services described herein. Regardless of my insurance benefits, if any. I understand that I am financially responsible for the fees for services rendered.

I have read the above and understand my financial responsibilities.

SIGNATURE OF PATIENT (Parent or Guardian if a Minor)

Date Signed