

## Southern Orthopedic Spine Surgery-Dr. Gaiser REGISTRATION FORM

Today's Date:				PCP:			
<b>PATIENT INFORMATION</b>							
Patient's Last Name:		First:		Middle:		Marital status:	
Is this your legal name? <input type="radio"/> Yes <input type="radio"/> No	If not, what is your legal name?		Former Name:		Birth Date:	Age:	Sex: <input type="radio"/> M <input type="radio"/> F
Address: [Address/ P.O. Box, City, ST ZIP Code]							
Social Security No.:		Home Phone No.:			Cell Phone No.:		
Occupation:		Employer:			Employer Phone No.:		
How did you hear about us? PCP, Advertising, Word of Mouth, Patient in the Practice, Hospital or Insurance Company							
<b>INSURANCE INFORMATION</b>							
(Please give your insurance card to the receptionist.)							
Person Responsible for Bill:		Birth Date:		Address (if different):		Home Phone No.:	
Is this Patient Covered by Insurance?		<input type="radio"/> Yes <input type="radio"/> No					
Please indicate primary insurance:							
Subscriber's Name:		Subscriber's S.S. No.:		Birth Date:	Group No.:	Policy No.:	Co-Payment: \$
Patient's Relationship to Subscriber:							
Name of Secondary Insurance (if applicable):			Subscriber's Name:		Group No.:	Policy No.:	
Patient's Relationship to Subscriber:							
<b>IN CASE OF EMERGENCY</b>							
Name of local friend or relative (not living at same address):				Relationship to Patient:		Home/Cell Phone No.:	Work Phone No.:
<p>Are you here due to an automobile accident? Yes or No</p> <p>Are you here due to a work accident? Yes or No</p> <p>Do you currently reside in a nursing home? Yes or No</p> <p>Race: Caucasian/Asian/Native Hawaiian/Other Pacific Islander/African American/American Indian/Alaskan Native</p> <p>Ethnicity: Not Hispanic or Latino/Central American/Cuban/Dominican/Mexican/Puerto Rican/South American/Spaniard/Latin American-Latin, Latino/Hispanic</p>							
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Southern Orthopedic Spine Surgery-Dr. Gaiser or insurance company to release any information required to process my claims.</p>							
Patient/Guardian Signature						Date	