PATIENT REGISTRATION FORM **North Springs Surgical Associates, PC**

(Print clearly & press firmly in black ink)

☐ **William Lechuga, MD** ☐ **Michael McCann, MD** ☐ **Peter Zimmer, MD** ☐ **Daniela Botolin, MD** ☐ **Scott Deeney, MD**

Today's Date____________________ Date of Birth____________________

Patient Name____ Gender (circle) F M
(Last) (First) (MI)

Address ____
(Street) (Apt/Ste) (City) (State) (Zip)

Primary Phone ( )______________________________May we leave a message? (circle) YES / NO

Secondary Phone ( )______________________________May we leave a message? (circle) YES / NO

Work Phone ( )______________________________OK to call work? (circle) YES / NO

Patient's Employer____

Primary reason for today's visit____________________________________

____

Primary Care Physician____________________Referring Physician____________________
Last First Last First

Have you ever been seen in this office before?________ When?__________

Current insurance card(s) and photo identification are required for scanning. Please complete the following:

Primary Insurance ____________________Policy #/ID ____________________Group # __________

Name of Policy Holder ____________________Date of Birth __________Gender (circle) F M

Relationship to Patient__________ Employer ____________________Employer Phone ( )__________

Secondary Insurance ____________________Policy #/ID ____________________Group # __________

Name of Policy Holder ____________________Date of Birth __________Gender (circle) F M

Relationship to Patient__________ Employer ____________________Employer Phone ( )__________

If you are a Medicare beneficiary, please circle any of the following that apply to you:

(circle) **Working-Aged** **ESRD** **Auto/Med/No Fault Liability** **Workers Comp** **Federal Black Lung** **Veterans Affairs** **Disability** **Other Liability**

Emergency Contact – Close friend or relative not living with you that we can contact in an emergency:

Name ____________________ Relationship ____________Phone( )______________
Last First

Authorized Signature______________________________ Date____________