PETOSKEY
SURGEONS, PC
Northern Michigan's leading center of surgical excellence.

Patient Registration Form

All information you provide will be protected as directed by the Federal Trade Commission and other federal agencies to protect consumer information.

PATIENT INFORMATION

Patient Name **Last:**	**First**	M.I.:	
Mailing Address:	City:	State:	Zip:
Seasonal Address:	City:	State:	Zip:
Social Security # – –	Date of Birth: Age:	Patient's Gender: ❑ M ❑ F	
Race: Ethnicity:	Email:	Preferred Language:	
Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Divorced	Employed ❑ Full Time ❑ Part Time ❑ Retired ❑ Not Employed	Student ❑ FT ❑ PT ❑ Not a student	
Employer Name:	Employer Address:		

PATIENT PHONE NUMBERS

Home:	Cell:	Work:

EMERGENCY CONTACT

Name:	Relationship:	Phone:

PRIMARY CARE PHYSICIAN – REFERRING PHYSICIAN

Primary Care Physician:	**Referring Physician:**
Referred By: ❑ Insurance ❑ Phone Book ❑ Friend ❑Physician	Name:

GUARANTOR – RESPONSIBLE PARTY – SPOUSE – GUARDIAN INFORMATION

Responsible Party Name:	Date of Birth:	SSN: - -
Mailing Address:		
Home Phone:	Cell Phone:	Work Phone:

INSURANCE INFORMATION

Primary Insurance Co.:	Group #:	ID #:
Policyholder Name:	Patient Relationship to Policyholder: ❑Self ❑Spouse ❑Dependent	
Policy Holder's Social Security #: - -	Policy Holder's Date of Birth:	Gender: ❑M ❑F

If the patient is covered by another insurance policy, please complete the following information for coordination of benefits. This information will enable your insurance company to process your claim more quickly. Thank you!

Secondary Insurance Co.:	Group #:	ID #:
Policyholder Name:	Patient Relationship to Policyholder: ❑Self ❑Spouse ❑Dependent	

AUTHORIZATION: I authorize that payment of benefits be made on my behalf to Petoskey Surgeons, P.C. for any services furnished to me. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges not covered by this assignment, for charges for services without an appropriate referral by a Primary Care Physician when required by my insurance plan, and/or charges resulting from the provision of inaccurate or incomplete insurance information. I authorize the release all information necessary to secure the payment and for my continuing medical care. I realize that I will be liable for payment of co-payment liabilities and deductibles, as may be required by my insurance plan, **and that these are collected when I check in for a visit.**

Signed: Date: