Indiana Surgical Associates P.C.

Patient Registration Form

Patient Information

Patient Information: (PLEASE FILL OUT ALL SECTIONS BELOW)

Last Name:	First Name: MI:	Previous Name (if applicable)	
Mailing Address:			Sex: ☐ Male ☐ Female
Home Phone:	Cell Phone:	Work Phone:	
Social Security #:	Date of Birth:	Referring Physician:	Primary Physician:
Email Address:		Marital Status: ☐ Married ☐ Divorced ☐ Legally Seperated ☐ Single ☐ Widowed ☐ Partner	
Employment Status: ☐ Full Time ☐ Not Employed ☐ Retired ☐ F/T Student ☐ Part Time ☐ Self Employed ☐ Active Military ☐ P/T Student		Employer Name:	
Pereferred Pharmacy & Location:		Preferred Language (please select one): ☐ English ☐ Spanish ☐ Other (please list): ☐ Sign Language ☐ Chinese	
Emergency Contact Name:		Emergency Contact Phone #:	
Emergency Contact Address:			Relationship to Patient:

Additional Information:

Race: ☐ White ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Hispanic ☐ American Indian or Alaska Native ☐ Asian ☐ Decline to Specify

Ethnicity: ☐ Hispanic or Latino ☐ Decline to Specify ☐ Not Hispanic or Latino

Responsible Party

Responsible Party: *If the patient is a minor (under the age of 18), the parent or guardian bringing the patient in will be listed as the guarantor*

☐ **PUT AN "X" IN THIS BOX IF INFORMATION IS SAME AS PATIENT**

Last Name:	First Name:	
Date of Birth:	Social Security #:	Phone:
Address of Person Responsible:		Relationship to Patient:

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Insurance Co. Name:	Insurance Co. Name:
Policy Holder Name:	Policy Holder Name:
Policy #:	Policy #:
Group ID:	Group ID:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

Communication Preferences

Communication with Others: *These communications may include information such as test results, medications, appointments, instructions regarding treatments, and billing information.*

Please check one of the boxes below:

☐ **YES**, you may share my health information with the following individuals *(list names)*:

Name: ______________________ Relation: ______________

Name: ______________________ Relation: ______________

Name: ______________________ Relation: ______________

☐ **NO**, I prefer that my doctor or staff speak to only myself, personally, regarding any medical information.

Message Preferences: *These messages may include information such as test results, medications, appointments, instructions regarding treatments, and billing information.*

Please check one of the boxes below:

☐ **YES**, you may leave messages on my answering machine or voicemail: ☐ at Home ☐ on Cell Phone ☐ at Work

☐ **NO**, Please do not leave messages on my answering machine or voicemail.

Signature of Patient or Guardian: X ______________________ **Date:** ______________