

**LGH-A/Golf ASTC,LLC
dba Golf Surgical Center**

8901 Golf Road, Des Plaines, IL 60016 – 847-299-2273

You have been scheduled for surgery at our facility on _____

Please complete this pre-registration form and either fax it to us at 847.299.2297 or mail back in the enclosed envelope.

PATIENT INFORMATION			
Last Name:	First Name:	MI:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F DOB: Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W
Address:		City, State Zip:	
Home Phone	Work Phone	Ethnicity (check one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino	
Social Security No.	Employer/School (if student)	Race (check one) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Hawaiian/Pacific Island <input type="checkbox"/> White	
Employer Address		City, State Zip	
PARENT/INSURED POLICY HOLDER NAME (RESPONSIBLE PARTY)			
Last Name	First Name	Relationship	DOB
Address		City, State Zip	
Home Phone	Work Phone	Employer	
Employer Address		City, State Zip	
INSURANCE INFORMATION			
WORKMANS COMP? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Primary Insurance Name		Primary Insured Last Name	Primary Insured First Name DOB
Address of Primary Insurance		City, State Zip	
SSN of Insured	Insured ID Number	Group Number	Insurance Phone #
Insured Employer		Insured Employer Address	
Secondary Insurance Name		Insured Last Name	Insured First Name DOB
Address of Secondary Insurance		City, State Zip	
SSN of Insured	Insured ID Number	Group Number	Insurance Phone #
Insured Employer		Insured Employer Address	

ADVANCED DIRECTIVES

Do you have a Living Will or Advanced Directive? YES NO

Information on Advanced Medical Directive can be found at the following website: www.idph.state.il.us/public/books/advin.htm

I understand that Advanced Directives/Living Wills are not honored at Golf Surgical Center and in the event of a life threatening situation, advanced cardiac life support will be instituted in every instance and patients will be transported to a higher level of care.

ASSIGNMENT OF BENEFITS - I hereby assign benefits to be paid, on my behalf, to Golf Surgical Center for services rendered to me. I understand and agree to be financially responsible for all charges whether or not they are covered by insurance or other third party payors. In the event of default, I agree to pay all cost of collection and reasonable attorney fees.

RELEASE OF INFORMATION - I hereby authorize Golf Surgical Center to release all or part of my medical records when required for submission of any insurance claims for payment of services rendered by the center. The center, its agents, servants, and employees who render services to me are hereby released from any and all liability of any nature that may arise from the release of such information.

DISCLOSURE AGREEMENT - I have been informed that the physician who is rendering services may have an ownership interest in Golf Surgical Center. I have been given the option to be treated at another facility, which I have declined. I choose to be treated at Golf Surgical Center.

YOU WILL RECEIVE AT LEAST 3 SEPARATE STATEMENTS: Golf Surgical Center for the facility fee, your Physician for the professional fee, and the Anesthesia services for the anesthesia fee. You may receive a statement if your physician orders any Lab or Pathology to be performed on specimens obtained during your visit to the center.

I agree that a photocopy of this agreement shall be valid as the original. I certify by my signature that I have read the foregoing and that I understand completely and fully accept the terms specified therein.

Parent/Insured/Responsible party signature

Date