

Golf Surgical Center
8901 Golf Road
Des Plaines, IL 60016

PATIENT REGISTRATION FORM

Phone: (847)299-2273
 Fax: (847)299-2297

You have been scheduled for surgery at our facility on _____ . Please complete this preregistration form and mail or fax it back to us as soon as possible.

PATIENT INFORMATION: Please Print

Last Name:		First Name:		MI:
Street Address		City	State	Zip
Home Phone () -	Work Phone () -	Birthdate / /	Sex M F	Marital Status S M D W
Social Security Number - -		Occupation (If student, name of school)		Employer
Employer Address		City	State	Zip

WORKMAN'S COMP CASE: YES NO	DATE OF INJURY:
IF YES, Contact person:	Phone: () -

PARENT/INSURED/POLICY HOLDER NAME: (Responsible Party)

Last Name:		First Name:		Relationship
Street Address		City	State	Zip
Home Phone () -	Work Phone () -	Employer		
Employer Address		City	State	Zip

INSURANCE INFORMATION: HMO PPO POS OTHER (Circle Type of Insurance)

Name of Primary Insurance Company		Name of Insured (Policy Holder)		Date of Birth / /
Social Security of Insured - -	Policy No.	Group No.	Insurance Phone No. () -	
Address of Insurance Company		City	State	Zip
Name of Secondary Insurance Company		Name of Insured (Policy Holder)		Date of Birth / /
Social Security of Insured - -	Policy No.	Group No.	Insurance Phone No. () -	
Address of Insurance Company		City	State	Zip

AUTHORIZATION

I understand that I am financially responsible to Golf Surgical Center for any charges incurred by the above named patient, and promise to pay promptly to Golf Surgical Center the amount of such charges which is not paid by my insurance carrier for any reasons. I authorize the release of any medical or financial information to the above named insurance company(s) necessary to process any claim for benefits with such company(s).

 Parent/Insured/Responsible party's signature

 Date