PATIENT REGISTRATION FORM

North Springs Surgical Associates, PC

(Print clearly & press firmly in black ink)

☐ William Lechuga, MD ☐ Michael McCann, MD ☐ Peter Zimmer, MD ☐ Scott Mattsson, MD ☐ Daniela Botolin, 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_____