Pacific Rim
OUTPATIENT SURGERY CENTER

Patient Registration Form

SURGERY DATE:	SURGEON:

LAST NAME:	FIRST NAME:	MI:

ADDRESS: Street	City	State	Zip

MAILING ADDRESS (if different from above):	City	State	Zip

HOME PHONE:	CELL PHONE:	WORK PHONE:	EMPLOYER:

GENDER: M F	DATE OF BIRTH:	AGE:	MARITAL STATUS: S M D W	SS #:	DRIVERS LICENSE # & STATE :

***** *IS THE PATIENT LIVING IN A SKILLED NURSING FACILITY? NO YES IF YES, ARE THEY A FULL TIME RESIDENT? NO YES*

NAME OF SPOUSE:	SPOUSE'S SS#	DAY PHONE:
SPOUSE'S EMPLOYER:	WORK PHONE:	CELL PHONE:

IF PATIENT IS A MINOR		
PRIMARY RESPONSIBLE PARTY & RELATION:	PHONE # (if different than above)	EMPLOYER:
SECONDARY RESPONSIBLE PARTY & RELATION:	PHONE # (if different than above)	EMPLOYER:

EMERGENCY CONTACT INFORMATION	
EMERGENCY CONTACT (not at same address):	RELATION TO PATIENT:
ADDRESS:	DAY PHONE:

INSURANCE INFORMATION (Please present insurance card(s) to Receptionist)		
PRIMARY INSURANCE:	POLICY OR ID#:	GROUP#:
SUBSCRIBER'S NAME:	SUBSCRIBER SS#:	SUBSCRIBER DOB:
SECONDARY INSURANCE:	POLICY OR ID#:	GROUP#:
SUBSCRIBER'S NAME:	SUBSCRIBER SS#:	SUBSCRIBER DOB:

IS THIS SURGERY DUE TO AN ON-THE-JOB INJURY? If so, please provide:	
WORKER'S COMP INSURANCE:	**EMPLOYER AT THE TIME OF INJURY:**
CLAIM #:	**DATE OF INJURY:**

I authorize treatment of the person named above and agree to accept full financial responsibility for payment regardless of third party responsibility. I authorize the release of any medical information requested by my insurance company. I authorize payment of medical benefits to **Pacific Rim Outpatient Surgery Center**. Finance charges may be charged to personal balance accounts over 90 days at the rate of 12% year. I authorize vendor representatives to be present at the time of my procedure/surgery when necessary. If cancer is diagnosed by the pathologist, I agree that medical records relating to this cancer may be recorded in the Tumor Registry. I authorize **Pacific Rim Outpatient Surgery Center** and my surgeon to take photographs during my procedure/surgery. In the event of an accidental exposure of my blood/ body fluids with another person, I agree to have my blood tested for the Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), and the Hepatitis C Virus (HCV). Advance Directives will not be honored at **Pacific Rim Outpatient Surgery Center.**

PATIENT SIGNATURE:	DATE:
RESPONSIBLE PARTY (if patient is a minor):	RELATIONSHIP TO PATIENT: