SEQUOIA SURGICAL PAVILION - REGISTRATION FORM

Patient Name: _____ Date of Birth:_____

Address: _____ City:_____

State/ZIP_____ Work Phone_____ Email:_____

Home Phone_____ Cell Phone_____

Social Security Number _____ Are you a new patient to Sequoia? _____

Financial Responsible Party:_____ Employer: _____

Are you from a Skilled Nursing Facility (SNF)? _____ If yes, name_____

PRIMARY INSURANCE: **Bolded Items MUST be completed by Responsible Party**

Carrier: _____ **Subscribers ID#:** _____

Subscriber's Name:_____ **Subscribers Date of Birth:**_____

Pt's relation to insured: _____ Subscribers Employer:_____

SECONDARY INSURANCE: **Bolded Items MUST be completed by Responsible Party**

Carrier: _____ **Subscribers ID#:** _____

Subscriber's Name:_____ **Subscribers Date of Birth:**_____

Pt's relation to insured: _____ Subscribers Employer:_____

If this is a work related injury please complete Worker's Comp section below.

WORKER'S COMP INSURANCE:

Carrier Name: _____ **Claim #:**_____

Adjustor's Name: _____ **Phone #** _____

Date of Injury:_____ **Employer**_____

I authorize the billing department to speak to _____ regarding my account. (I.E., spouse's name, parent name)

I verify that all of the above information is accurate.

Patient/Responsible Party Signature _____ **Date:** _____