PATIENT REGISTRATION RECORD

R A. CAPONE, JR., M.D. P.C. AND SHADYSIDE SURGI-CENTER, INC.

PATIENT INFORMATION

Patient Name: ____

Address: ____

City/State: ____

Zip Code: ____

Home Phone (_____)____________-______________ preferred____

Cell / Altern. (_____)____________-______________ preferred____

E-Mail Address: ____

Next of Kin & Phone Number: ______________________________

Referred by Whom? 1. ______________________________

2. ______________________________

Reason for Visit: ____

Social Security No.: ________-________-__________

Patient's Employer: ______________________________

Patient's Sex: M F Allergies: Y N

Birth date: _______/________/_______ Age: ___________

Marital Status: ____________________

Primary Physician: ______________________________

Primary Physician Phone No: (_______)__________-________

Do you grant us permission to send Confidential Health Information to your Primary Physician? Y N

Accident Related? Y N Date of Accident ________

GUARANTOR INFORMATION (Party Responsible for Payment of Personal Balance)

Guarantor Information Same as above ☐

Guarantor Name: ____

Address: ____

City, State, Zip Code: ______________________________

Patient Relationship to Guarantor: ________________________

Guarantor Social Security No. ___________-_______-_________

Guarantor Birth date: ________/________/________ Sex: M F

Guarantor Phone No. (______)__________-______________

INSURANCE INFORMATION

Primary

Name of Insurance Company: ____

Name of Policy Holder: ______________________________ Relationship to Patient: ______________ Policy Holder Birth date: _____/_____/_____ Sex: M F

Policy/Claim/ID#____________________________ Group Number: __________________________ Effective Dates: ________________________

Annual Deductible: ______________________ How much of your Annual Deductible has been met? ______________________________

Coinsurance Rate: _______ /_______%

Secondary

Name of Insurance Company: ____

Name of Policy Holder: ____________________ Relationship to Patient: ____________________ Policy Holder Birth date: ________/_______/________ Sex: M F

Policy/Claim/ID#____________________________ Group Number: __________________________ Effective Dates: ________________________

Annual Deductible: ______________________ How much of your Annual Deductible has been met? ______________________________

Coinsurance Rate: _______ /_______%

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR FEES NOT REIMBURSED BY MY INSURANCE CARRIER. FEES ARE THE DIRECT OBLIGATION OF THE PATIENT OR RESPONSIBLE PARTY. WHILE INSURANCE FORMS ARE PREPARED AS A COURTESY, PAYMENT REMAINS THE PATIENT'S RESPONSIBILITY. THE AMOUNT REIMBURSED BY THE INSURANCE COMPANY REMAINS A MATTER BETWEEN YOU AND YOUR INSURANCE CARRIER.

I ACKNOWLEDGE THAT I HAVE BEEN PROVIDED WITH A COPY OF THE NOTICE OF PRIVACY PRACTICES.

SIGNATURE OF PATIENT

OR RESPONSIBLE PARTY: ____ **DATE**: __________________________

5727 CENTRE AVENUE, PITTSBURGH, PA 15206 PHONE: (412) 363-6626 FAX: (412) 363-7008