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

PATIENT INFORMATION

Address:	Patient Name:		Social Security No.:
City/State: Zip Code: Patient's Sex: M F Allergies: Y N Home Phone (Patient's Employer:
Patient's Sex: M F Allergies: Y N			
Home Phone			Patient's Sex: M F Allergies: Y N
Cell Altern			Birth date:/Age:
E-Mail Address: Primary Physician: Primary Physician Phone No:	Cell / Altern. (preferred	
Next of Kin & Phone Number:	E-Mail Address:		
Reason for Visit:			Primary Physician Phone No: (
Reason for Visit:	Referred by Whom? 1.		Do you grant us permission to send Confidential Health
GUARANTOR INFORMATION (Party Responsible for Payment of Personal Balance) Guarantor Information Same as above			Information to your Primary Physician? Y N
Guarantor Information Same as above Guarantor Information Same as above Guarantor Information Same as above Guarantor Social Security No. Guarantor Name: Guarantor Name: Guarantor Social Security No. Sex: M F City, State, Zip Code: Guarantor Phone No. Guarantor Phone No. Sex: M F City, State, Zip Code: Guarantor Phone No. Sex: M F City, State, Zip Code: Guarantor Phone No. Sex: M F City, State, Zip Code: Guarantor Phone No. Sex: M F City, State, Zip Code: Guarantor Phone No. Sex: M F City, State, Zip Code: Guarantor Phone No. Sex: M F City, State, Zip Code: Guarantor Phone No. Sex: M F City, State, Zip Code: Guarantor Phone No. Sex: M F City, State, Zip Code: Guarantor Phone No. Sex: M F Policy Holder Birth date: Sex: M F Policy Holder: Sex: M F Policy Holder Birth date: M F Sex: M F Policy Holder: Sex: M F Policy Hold			Accident Related? Y N Date of Accident
Guarantor Name: Guarantor Social Security No		` •	· /
Address:			
City, State, Zip Code:			
INSURANCE INFORMATION Primary Name of Insurance Company: Name of Relationship Policy Holder:			
Primary Name of Insurance Company: Name of Relationship Policy Holder:	City, State, Zip Code:		Guarantor Phone No. (
Policy Holder:	Name of Insurance Company:		
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 Relationship Policy Holder: 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			•
Annual Deductible:			
Coinsurance Rate: / % Secondary Name of Insurance Company:			
Name of Insurance Company: Name of Relationship Policy Holder:			
Name of Relationship Policy Holder:			
Name of Relationship Policy Holder:	Name of Insurance Company:		
Policy/Claim/ID# Group Number: Effective Dates: 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.		Relationship	
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	Policy Holder:	to Patient:	Policy Holder Birth date:/ Sex: M F
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.	Policy/Claim/ID#	Group Number:	Effective Dates:
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OR RESPONSIBLE PARTY: DATE:	SIGNATURE OF PATIENT		
	OR RESPONSIBLE PARTY:		DATE: