SJLSC
San Joaquin Laser & Surgery Center

# PATIENT REGISTRATION FORM

Patient's Last Name _____ First _____ M.I. _____

Address _____ City _____State _____ Zip _____

Email _____ Primary Phone: _____

Date of Birth_____ Social Security:_____ Gender: Male / Female

Ethnicity: _____ Race:_____ Preffered Language:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner

**Do we have permission to speak with your spouse or partner regarding your medical care? Yes No**

Spouse/Partner Name: _____ Spouse/Partner Phone Number: _____

**Emergency Contact (not living with you):** Name: _____

Phone Number: _____Relationship_____

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|---|---|
| **Primary** Insurance Company Name: | Primary Subscriber Name:<br>DOB: Social Security #: |
| Policy (ID)Number: | Relationship to Patient: Self ( ) Spouse ( ) Parent ( ) |
| | |
| **Secondary** Insurance Company Name: | Secondary Subscriber Name:<br>DOB: Social Security #: |
| Secondary Policy Number: | Relationship to Patient: Self ( ) Spouse ( ) Parent ( ) |

**1. MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to **San Joaquin Laser & Surgery Center**, for services furnished to me by **San Joaquin Laser & Surgery Center.** I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid services (formerly Health Care Financing Administration) and its agents. Any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated on Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. **San Joaquin Laser & Surgery Center** accepts the chare determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

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**2. MEDIGAP:** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the HCFA 1500 form or elsewhere on other approved claim forms, my signature authorized release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to **San Joaquin Laser & Surgery Center.**

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**3. Private/HMO/PPO:** I request payment of benefits be made on my behalf to **San Joaquin Laser & Surgery Center** for services furnished to me by **San Joaquin Laser & Surgery Center**. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

_____ _____

Beneficiary Signature or Authorized Party Date