

**PATIENT REGISTRATION  
INFORMATION**

Is your condition a result of a work injury? YES NO      An auto accident? YES NO      Date of Injury \_\_\_\_\_

**PATIENT'S PERSONAL INFORMATION** Marital Status:  Single  Married  Divorced  Widowed Sex:  M  F

Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_ (Apt #) \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Employer/School \_\_\_\_\_ Address: \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_  
Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Spouse's Employer/School \_\_\_\_\_ Address: \_\_\_\_\_

**PATIENT'S INSURANCE INFORMATION** *Please present insurance cards to receptionist  
(If Self or Spouse is checked as insured, just list Insurance Company and ID Number and Group Number)*

Relationship to Insured  Self  Spouse  Child  Other  
PRIMARY INSURANCE COMPANY'S NAME: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Insurance ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Relationship to Insured  Self  Spouse  Child  Other  
SECONDARY INSURANCE COMPANY'S NAME: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Insurance ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Check if appropriate:  Medigap Policy  Retiree Coverage

**PATIENT'S REFERRAL INFORMATION**

Referred By: \_\_\_\_\_ If referred by a friend, may we thank him or her? YES NO  
Name(s) of other physicians who care for you: \_\_\_\_\_  
\_\_\_\_\_

**EMERGENCY CONTACT**

Name of person not living with you: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Street Address: \_\_\_\_\_ (Apt #) \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Work Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

*Assignment of Benefits and Financial Agreement*

*I hereby give lifetime authorization for payment of insurance benefits to be made directly to Langhorne Surgical Group, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I further agree that a photocopy of this agreement shall be as valid as the original. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Langhorne Surgical Group for any service furnished me by physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration or other insurance company and its agents any information needed to determine these benefits or the benefits payable for related services.*

Date: \_\_\_\_\_ Your Signature: \_\_\_\_\_