# PATIENT REGISTRATION

DATE________________________ FAMILY/REFERRING DR.________________________________

PATIENT NAME______________________________________ BIRTH DATE____/____/____

ADDRESS__________________________ CITY__________________ STATE______ ZIP_______

EMAIL________________________ DRIVERS LICENSE______________________________

PATIENT S.S. #________________________ PHONE__________________________ AGE________

SEX M ☐ F ☐ MARITAL STATUS S ☐ M ☐ W ☐ D☐ Cell Phone____________________

PATIENT EMPLOYER &ADDRESS________________________________________________

EMPLOYER PHONE__________________________________________________________

REASON FOR VISIT__________________________________________________________

REFERRED BY WHOM________________________________________________________

SPOUSE OR NEAREST RELATIVE______________________________ PHONE______________

ADDRESS______________________________________ RELATIONSHIP_______________

RESPONSIBLE PERSON NAME_______________________________ S.S. #______________

ADDRESS__________________________________________________________________

PHONE (H)____________________(W)____________________ RELATIONSHIP_____________

EMPLOYER & ADDRESS_______________________________________________________

INSURANCE INFORMATION

PRIMARY CARRIER__________________________________ SUBSCRIBER______________

ADDRESS__________________________________________________________________

I D #__________________________ GROUP # ____________________ PLAN______________

SECONDARY CARRIER_______________________________________________________

ADDRESS__________________________________________________________________

I D #__________________________ GROUP #____________________ PLAN______________

I HEREBY AUTHORIZE DR. PECK, AND WHERE APPLICABLE, ESSEX SURGICAL, LLC, AND /OR THE ANESTHESIOLOGIST TO RELEASE ANY INFORMATION REGARDING SERVICES RENDERED AND ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED TO FILE INSURANCE. I ALSO AUTHORIZE AND DIRECT PAYMENT FOR BENEFITS DUE ME FOR THE SERVICES RENDERED BY THE PREVIOUSLY NAMED PARTIES TO BE MADE TO HIM/THEM REGARDLESS OF MY INSURANCE BENEFITS. PHOTOCOPIES OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR THE FEES FOR SERVICES RENDERED. OUTSIDE LABORATORY FEES ARE THE PATIENTS RESPONSIBILITY.
WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS. THIS MAY INCLUDE FAXING INFORMATION FOR HEALTHCARE PURPOSES AND BILLING, AS WELL AS LEAVING MESSAGES FOR APPOINTMENTS AND HEALTH CARE (PRE/POST OPERATIVE CALLS ARE INCLUDED).

NAME______________________________________________ DATE____________________

PATIENT SIGNATURE/RESPONSIBLE PERSON