SURGICAL ARTS PC
PATIENT REGISTRATION FORM

Date ______________________________ **Medical Record #**________________

First Name_____________________ **Middle Name**_______________ **Last Name**_________________________________
Mailing Address____
City____**State**____________ **Zip Code**_____________
Home Telephone Number (   ) ____________________________ **Cell Phone Number:** (   )_________________
Sex: ☐ Female ☐ Male **Number of Children:** ________**Marital Status:** ☐Married ☐Single ☐Divorced ☐Widowed
Race: ☐ A-Asian/Oriental ☐B-Black/African American ☐D- Declined ☐H-Native Hawaiian/Other Pacific Islander
☐ I-American Indian/Alaska Native ☐ O-Hispanic and/or Other ☐ U-Unknown ☐W-White
Ethnicity: ☐Decline ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
Date of Birth: ____________________________**Age**:_______ **Social Security Number:** ________-_________- _______
Driver's License Number:_______________________ **Language:** ☐ ENG-English ☐ SPA-Spanish ☐ Other_______
Email Address for Medical Record Access:____

EMPLOYER INFORMATION

Name of Employer ____________________________________Occupation_________________________________
Employer's Phone Number (   )___________________ Ext _______ Department ______________________________
Date of Sickness or Accident ___________________________ Is injury work related? ☐Yes ☐No

PHYSICIAN INFORMATION

Which physician are you seeing? ☐Windham ☐Smith ☐Evans ☐Moody ☐McBride ☐Pearce ☐Graves NP
Name of Referring Physician____
Name of Family Physician ____

INSURANCE INFORMATION

Name of Primary Insurance____
Policy Holder Name ____Date of Birth_____________________
Name of Secondary Insurance____
Policy Holder Name ____Date of Birth_____________________

SPOUSE INFORMATION

Spouse's Name____
Spouse's Date of Birth________________________ Spouse's Social Security Number ________ - __________-________
Spouse's Name of Employer____ Occupation__________________________
Spouse's Employer's Phone Number (   ) __________________________ Ext______________ Department___________

PARENT INFORMATION (If patient is a minor)

Father's Name ____________________________________ Mother's Name____
Father's Date of Birth ___________________________________ Mother's Date of Birth ______________________________
Father's Social Security Number ________________________ Mother's Social Security Number______________________
Father's Name of Employer_____________________________ Mother's Name of Employer____________________________
Father's Employer's Phone Number (   )________________ Ext _______Department_____________________________
Mother's Employer's Phone Number (   )________________ Ext _______Department_____________________________

EMERGENCY CONTACT INFORMATION (Name of someone not living in same house)

First Emergency Contact Person____Relationship________________
Emergency Contact Phone Number (   ) ____
Second Emergency Contact Person____ Relationship_______________
Emergency Contact Phone Number (   )____

PLEASE PAY DEDUCTIBLE AND CO-PAY AMOUNT TODAY. IF YOU HAVE NO INSURANCE, PAYMENT FOR VISIT IS DUE AT TIME OF VISIT.
SURGICAL ARTS PC: OFFICE NUMBER: 256-734-7850 FAX NUMBER : 256-734-9633