PATIENT REGISTRATION

Patient Name: _____ SS# _____

Date of
Birth: _____ Sex: M ___ F __ Race: _____ Religion: _____

Mailing Address: _____ City: _____ State: ____ Zip: _____

Telephone: _____ Work: _____

Cell: _____ Spouse's Name: _____ Insured Name: _____

Spouse's employer/address: _____

Family Doctor: _____ Telephone: _____

Emergency Contact: _____Telephone: _____ Relationship: _____

Do you have an Advanced Directive: Yes___ No ___
Are you aware it is not honored at this facility: Yes ___ No ___
* (If you would like information on Advanced Directives, please ask our staff)

PATIENT EMPLOYER INFORMATION

Employer Name: _____Telephone: _____

Employer Addresss: _____ City/State: _____

Occupation: _____ Zip: _____

CANCELLATION POLICY

I understand CSEC policy requires 48 hour's notice prior to the cancellation of procedure date. I understand that I may be billed for not contacting CSEC regarding cancellation of my procedure.

Signature: _____ Date: _____
(Patient, Parent, Guardian)

AUTHORIZATION

I authorize the release of any medical information to my insurance carrier that may be necessary to process my claims. I permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____
(Patient, Parent, Guardian)