CAPITAL SURGICAL

REGISTRATION FORM

(Please Print)

Today's date:	PCP:	Referring Dr:

PATIENT INFORMATION

Name:

Last: First: Middle Initial:

Birth Date:	Social Security No.:	Sex: ❑Male ❑Female ❑Transgender	
Street address:	Home Phone: ( )	Cell phone: ( )	
City	State	ZIP Code:	Email Address:
Ethnicity: ❑Hispanic or Latino ❑Not Hispanic or Latino	Race: ❑American Indian/Alaskan Native ❑Asian ❑Black or African American ❑Native Hawaiian or Pacific Islander ❑ White		

Language: ❑English ❑Spanish ❑Other:_____

Marital Status
❑Married ❑Divorced ❑Legally Separated ❑Widowed ❑Partner

BILLING & INSURANCE INFORMATION

Is the patient covered by insurance? ❑Yes ❑No

Is this due to a work related accident? ❑Yes ❑No
Date of Injury:_____

Responsible Party Name	Birth Date:	Social Security No:	Phone No: ( )

Primary Insurance

Name of Carrier:	Social Security No:	Date of Birth:

Secondary Insurance

Name of Carrier:	Social Security No:	Date of Birth:

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

Patient/Guardian signature *Date*