SA SURGICAL ASSOCIATES

Board Certified · General Surgery · Surgical Critical Care · Colon & Rectal Surgery

Suite 900, Warren Prof. Bldg., 6465 South Yale, Tulsa, OK 74136-7822 • 2930 South Elm Place, Suite 215, Broken Arrow, OK 74012-7816 • T. 918/481-4800 • 800/311-4377 • Fax 918/481-4826

PATIENT REGISTRATION AND AUTHORIZATION

PATIENT

PATIENT NAME (LAST, FIRST, MIDDLE)	SOCIAL SECURITY NUMBER

DATE OF BIRTH	AGE	SEX	LANGUAGE	MARITAL STATUS
		☐ M ☐ F	☐ French ☐ Japanese ☐ Portuguese ☐ English ☐ Italian ☐ Spanish ☐ Other	☐ Legally Separated ☐ Married ☐ Single ☐ Divorced ☐ Life Partner ☐ Never Married ☐ Widowed

RACE	ETHNICITY
☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Other________	☐ Hispanic or Latino ☐ Not Hispanic or Latino

ADDRESS	CITY, STATE	ZIP CODE

TELEPHONE	PAGER/CELL PHONE	REFERRING PHYSICIAN

EMPLOYER	EMPLOYER ADDRESS	CITY, STATE	ZIP CODE

EMPLOYER TELEPHONE	EXTENSION	PATIENT'S E-MAIL

GUARANTOR

RELATIONSHIP TO PATIENT	GUARANTOR NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	AGE	SEX
					☐ M ☐ F

ADDRESS	CITY, STATE	ZIP CODE

TELEPHONE	PAGER/CELL PHONE	EMPLOYER

EMPLOYER TELEPHONE

EMERGENCY CONTACT

NAME		RELATIONSHIP TO PATIENT
TELEPHONE	EMPLOYMENT TELEPHONE	PAGER/ CELL PHONE

PHARMACY

NAME	
LOCATION/ADDRESS	

PRIMARY INSURANCE

INSURANCE COMPANY NAME	
ID#	GROUP#
PATIENT'S RELATIONSHIP TO SUBSCRIBER	
SUBSCRIBER'S NAME	
SUBSCRIBERS SS#	DOB

SECONDARY INSURANCE

INSURANCE COMPANY NAME	
ID#	GROUP#
PATIENT'S RELATIONSHIP TO SUBSCRIBER	
SUBSCRIBER'S NAME	
SUBSCRIBERS SS#	DOB

FINANCIAL RESPONSIBILITY, AUTHORIZATION TO RELEASE INFORMATION & FINANCIAL DISCLOSURE:

I assign to Surgical Associates, Inc., any and all health insurance benefits and other public and private benefits covering the medical treatment provided to me, and I direct that all payments for such services be made directly to Surgical Associate, Inc. I understand that I am financially responsible for all insurance deductibles, coinsurance payments and for the cost of all medical treatment that is not covered by insurance or for which there are no other benefits available.

Surgical Associates' physicians have an ownership interest in *Oklahoma Surgical Hospital, LLC, Artesian Cancer Center LLC, Breast PET, LLC and Sleep Solutions, LLC,* and your physician may refer you to one or more of these facilities for medical treatment. Please let your physician know if you have any questions about these medical facilities. By signing below, you acknowledge the disclosure of your physician's ownership interest in these medical facilities and you consent to treatment at these facilities.

I consent to the disclosure of my Protected Health Information to my health insurance provider, and to all other public and private providers of benefits, if any, for my medical treatment. I additionally consent to the disclosure of my Protected Health Information to all medical providers that are necessary for my medical treatment.

SIGNATURE______________________________ DATE________________