BRECKENRIDGE SURGERY CENTER

PATIENT REGISTRATION

Denton Watumull, MD
Joshua Lemmon, MD

Bruce Byrne, MD
Derek Rapp, MD

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: _____

Marital Status: Married _____ Single _____ Divorced _____ Separated _____ Widowed _____

Sex: Female _____ Male _____ Date of Birth _____/_____/_____ Age: _____

Social Security: _____ Driver's License Number: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____-_____ Alternative Number (_____) _____-_____

Student Status: Full Time _____ Part Time _____ N/A _____

GUARANTOR (Primary Insured):

Last Name: _____ First Name: _____ Middle Initial: _____

Address (if different than patient's): _____

Relation to patient: _____ Sex: Female _____ Male _____

Home Phone: (_____) _____-_____ Driver's License Number: _____

Date of Birth: _____/_____/_____ Social Security Number: _____

Employer: _____ Work Phone: (_____) _____-_____

Address: _____

City: _____ State: _____ Zip Code: _____

Employment Status: Full Time _____ Part Time _____ Not Employed/Retired _____

Insurance Provider: _____ Policy Number: _____

Group ID: _____ PO Box: _____

EMERGENCY CONTACT

Name: _____ Relation to patient: _____

Address: _____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

CONTACT CONSENT

I, _____, the undersigned patient, authorize Breckenridge Surgery Center to contact me at the following numbers:

A). Via Phone:			Leave a message?
At Home:	Yes _____ No _____	Number: (_____) _____-_____	Yes _____ No _____
At Work:	Yes _____ No _____	Number: (_____) _____-_____	Yes _____ No _____
Cell Phone:	Yes _____ No _____	Number: (_____) _____-_____	Yes _____ No _____

C). Other Persons We May Leave A Message With:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Breckenridge Surgery Center to furnish information to insurance carriers concerning my illnesses, accidents, and treatments, and also assign to them all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance. I also understand that any additional co-pay, coinsurance, and/or deductibles are due at the time of service.

In case of overpayment, you will be refunded after your insurance pays the surgery bill. You are informed that any balance not paid in full within 90 days will be subject to an 18% interest fee.

Signature_____ Date_____
(Patient's signature or responsible party)

Notice concerning complaints
Complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation at the following address:

Department of State Health Services
Attn: Manager, Health Facility Compliance Group
Post Office Box 149347
Austin, Texas 78714-9347
1-888-973-0022