KANSAS SURGICAL
CONSULTANTS, LLP

PATIENT REGISTRATION

PATIENT	INSURANCE POLICY HOLDER
Social Security Number:	Last Name:
Last Name:	First Name: Initial:
First Name: Initial:	Address:
Date of Birth:	City: State: Zip:
Address:	Home Phone:
City: State: Zip:	Work Phone:
(H)Phone:	Cell Phone:
(W)Phone:	Sex: Date of Birth:
(C) Phone:	Social Security:
Sex:	Employer:
Marital Status:	**Primary Insurance**
Who referred you to our practice?	Insurance Company Name:
Who is your primary physician?	Name of Insured Person:
Employer:	Insurance I.D. No.
(Circle one) Full-Time Part-Time Self Unemployed Retired Military	Group Number:
Emergency Contact Information	**Secondary Insurance**
Name:	Insurance Company Name:
(H) Phone:	Name of Insured Person:
(W) Phone:	Insurance I.D. No.
(C) Phone:	Group Number:

Assignment and Financial Responsibility

I here by assign payment directly to Kansas Surgical Consultants, L.L.P. for surgical and/or medical benefits. I acknowledge that I accept full responsibility for any medical service rendered to me or anyone for whom I am legally responsible for. I understand I am financial responsible for charges even when insurance should provide coverage and does not pay a valid claim within 90 days, or for non covered services. I will be legally responsible for all collection costs involved with this account including all return check fees, court costs, attorney fees and other expenses incurred with collection if I default on this agreement. **I have received a copy of the KSC Financial Policy and agree to its terms. I acknowledge that the Notice of Privacy Practices of Kansas Surgical Consultants have been offered to me and are available upon request at any time.**

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Patient Signature (or guarantor if minor) Date

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Patient Name (printed)

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