

**Asante Surgical Associates—Patient Registration Form**

SW 520 Ramsey Ave, Suite 205

Grants Pass, OR 97527

Phone (541) 479-6777

Fax (541) 479-6779

**Nabiel Azar, DO**

**Aaron Martin, DO**

Name of Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Please Print

**\*\*PATIENT NAME:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**\*\*SPOUSE NAME:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Social Security #: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**\*\*EMERGENCY CONTACT** (A person not living at the same address)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**MEDICAL INSURANCE INFORMATION (Please bring cards so that we may take a copy)**

**\*\*Please let us know if your insurance company requires prior authorization\*\***

**PRIMARY INSURANCE:** \_\_\_\_\_ ID #: \_\_\_\_\_

Group #: \_\_\_\_\_ Insured Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_ ID #: \_\_\_\_\_

Group #: \_\_\_\_\_ Insured Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**FOR OUR RECORDS, PLEASE READ THE FOLLOWING AND SIGN BELOW:**

I hereby authorize the release of all medical information necessary to process claims and authorize my insurance company to make payment directly to the Physician. I understand that I am PERSONALLY responsible for any balance on my account regardless of insurance coverage and/or litigation that may be pending. I understand and agree that I will be charged an annual finance charge of 18% for any unpaid balance. I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on it. IF I DO NOT SIGN THIS AGREEMENT, I UNDERSTAND THAT PAYMENT WILL BE MADE AT THE TIME OF SERVICE!

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**ATTENTION MEDICARE PATIENT'S: PLEASE READ AND SIGN THE FOLLOWING FOR MEDICARE BILLING**

I authorize the Physician to release any medical or other information necessary to process Medicare claims to the Social Security Administration and/or their intermediaries or insurance carriers. I understand the Physician is a participating Medicare provider and requests government payments be made directly to him/her. I further permit a copy of this authorization be used in place of the original. I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on it.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_