



ALGONQUIN ROAD SURGERY CENTER, LLC
Patient Centered. Extraordinary Care.

Patient Information (Please Print)

Date: / /

Last Name		First Name		Middle Initial
Street Address		City	State	Zip Code
Home Phone () -	Cell Phone () -	Date of Birth / /	Sex M F	Marital Status S M D W
Email Address	Occupation (if student, name of school)		Employer	
Employer Address		City	State	Zip

Responsible Party (if different from Patient)

Last Name		First Name		Middle Initial	Relationship to Patient
Street Address		City	State	Zip Code	
Home Phone () -	Cell Phone () -	Date of Birth / /	Sex M F		

Insurance Information

Primary Insurance:

Name of Insured		Relationship to Patient		Insured's Date of Birth / /
Insurance Company		Policy Number		Group Number
Claims Address		City	State	Zip Code
Employer Address		City	State	Zip

Secondary Insurance:

Name of Insured		Relationship to Patient		Insured's Date of Birth / /
Insurance Company		Policy Number		Group Number
Claims Address		City	State	Zip Code

Workman's Comp Case Yes No	Date of Injury / /	Contact Person	Phone () -	Claim Number
Auto Accident Yes No	Date of Accident / /	Insurance Company	Phone () -	Claim Number

AUTHORIZATION

I understand that I am financially responsible for any charges incurred by the above named patient while he/she is at Algonquin Road Surgery Center. I understand that any and all amount not covered by my insurance carrier will become my responsibility and all accounts are to be paid in full within 90 days. I authorize the release of any medical or financial information to the above named insurance company(s) necessary to process any claim for benefits with such company(s).

Signature

Relationship to Patient

____/____/____
Date