ALFA SURGERY CENTER, LLC
256 LANDIS AVE SUITE 100
CHULA VISTA CA 91910

PATIENT REGISTRATION INFORMATION

Patient Name: (Last) (First) (Middle)

_____

Address: City: State: Zip:

_____

PHONE (Home) (cell) (work) Preferred Language:

_____

Sex: Male / Female Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

SSN: _____ DATE OF BIRTH: _____ RACE: _____

EMPLOYER: _____ OCCUPATION: _____

REFERRING PHYSICIAN

Referring Physician: Phone: Fax:

_____

Primary Physician: Phone: Fax:

_____

Reason for visit? How did you hear about our center?

_____

EMERGENCY CONTACT/ADVANCED DIRECTIVES

Name of emergency contact: Relationship to patient: Phone:

_____

ADVANCED DIRECTIVES: ☐ YES ☐ NO Requests Information ☐ YES ☐ NO Copy to chart? ☐ YES ☐ NO

I hereby authorize ALFA SURGERY CENTER, LLC to treat the patient listed above. I hereby authorize payment directly to the above named physician/physicians the amount due me in all pending claims for medical expenses payable under the terms of my insurance. I agree that any balance not covered by my insurance will be paid by me if the insurance determines it is my responsibility. I authorize any physician, hospital, or clinic to provide full detail of my dependent medical history and treatment to the above named physician(s). In addition, I authorize the physician's listed above to release any information necessary to assist in medical treatment and/or insurance payment.

PATIENT SIGNATURE: _____ DATE: _____