

CENTRAL LOUISIANA SURGICAL HOSPITAL

PATIENT REGISTRATION FORM

Please complete this form and return it to The Hospital in the attached self-addressed envelope as soon as possible. When you arrive for your scheduled surgery, please bring your insurance cards with you so that we can verify your coverage. Thank you for your cooperation.

Patient Last Name _____ First _____ M.I. _____

Surgery Date ___/___/___ Surgeon _____ Anes. Type _____

Outpatient Inpatient: Length of inpatient stay _____ Imaging

Procedure(s) _____

M/F _____ Marital Status _____ DOB ___/___/___ SSN _____ - _____ - _____ Drivers Lic. _____

Home Phone _____ Pt. Address _____

Work Phone _____

Cell Phone _____

Emergency Phone _____ Name & Relationship to Patient _____

Email Address: _____

Employment (F/P/R/N) _____ Student (F/P/N) _____ Employer/Occupation _____

IF PT. IS UNDER 18, PLEASE COMPLETE THE FOLLOWING:

Resp. Party _____ M/F _____ DOB ___/___/___
Last First M.I.

Relationship to Patient _____ Responsible Party SSN# _____ - _____ - _____

Address _____ Phone _____

Employer/Occupation _____

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Primary Insurance Secondary Insurance

Company _____

Address _____

Phone _____

ID/SSN _____

Policy/Group _____

Authorization _____

Group Plan Name _____

Subscriber Name _____

DOB & Relation ___/___/___ _____

Employer/Occupation _____

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Accident (Y/N) _____ Date of Injury ___/___/___ Location (State) _____ Employment Related (Y/N) _____

Automobile (Y/N) _____ Claim No.: _____ Attention: _____

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- Additional procedures may be necessary as above procedure(s) is/are being performed. Have you been informed of this and possible related additional charges? Yes _____ No _____ Initials _____
 - Previous Admit to The Hospital (Y / N) _____