

PLEASE COMPLETE AND BRING DAY OF PROCEDURE

Bedford Ambulatory Surgical Center Registration form

Primary Care Physician: _____ Date: _____

Last Name: _____ First Name _____ Middle: _____

Address: _____
(Street) (City) (State) (Zip Code)

Home Phone: _____ Date of Birth: _____ Soc. Security # _____

Employer: _____ Work Phone: _____

Spouse's Name: _____ Spouse's Employer: _____

Whom to Contact In Case of Emergency:
Name: _____ Relationship: _____ Phone # _____

Please fill out in entirety if the patient is a minor or if the responsible party is other than the patient.

Relationship: _____

Last Name: _____ First Name: _____ Middle: _____

Address: _____
(Street) (City) (State) (Zip Code)

Home Phone: _____ Date of Birth: _____ Soc. Security # _____

Employer: _____ Work Phone: _____

Insurance Information: Please fill out COMPLETELY.

Primary Insurance Company: _____ ID# _____ Group # _____

Address: _____ Phone # _____

Subscriber: _____ SS#: _____ DOB: _____

Relationship: _____

Secondary Insurance Company: _____ ID # _____ Group #: _____

Address: _____ Phone# _____

Subscriber: _____ SS#: _____ DOB: _____

Relationship: _____

PLEASE COMPLETE BACK OF FORM

Worker's Compensation Information: Please fill out COMPLETELY.

Whom did you work for when you were injured? _____
Address: _____ Work Phone # _____
Insurance Company: _____ Phone # _____
Address: _____
(Street) (City) (State) (Zip Code)
Date of Injury: _____ Claim # _____

Motor Vehicle Accident or Lawsuit: Please fill out COMPLETELY.

Insurance Company: _____ Phone # _____
Address: _____
(Street) (City) (State) (Zip Code)
Name of Subscriber to Policy: _____
Claim # _____ Date of Accident: _____
Name of Attorney: _____ Phone # _____
Address of Attorney: _____
(Street) (City) (State) (Zip Code)
If other, address to send claim to:

(Street) (City) (State) (Zip Code)

ADVANCED CARE DIRECTIVE INFORMATION:

Do you have a living will? Yes ___ No ___
Do you have a durable power of attorney for healthcare? Yes ___ No ___
If you checked "yes" to one or both of the above, please provide the names of the peoples or offices (e. g. your primary physician's office) that have a copy of your living will and or durable power of attorney for healthcare and provide a contact telephone number.

Name _____ Telephone # _____

REQUIRED SIGNATURE FOR ALL PATIENTS:

I have received a copy of the "Patient's Rights" RSA 151:21 and have received and understand the "Privacy Notice". I authorize Bedford Ambulatory Surgical Center (BASC) to use my patient information for quality and peer review.
I authorize BASC and any physician providing care to me, including but not limited to anesthesiologists/CRNAs, to release any medical information necessary to file a claim and payment of benefits directly to BASC. I request and assign the payment of authorized benefits (including Medicare) to be made on my behalf to BASC or any physician providing service during my treatment. I understand that if any fees are declined because I did not obtain prior approval from my Primary Care Physician or insurance company, that I am responsible for those fees. I understand that I am ultimately responsible for payment to BASC.

Patient or Authorized Representative Signature _____

If Representative, Relationship to Patient _____