BEDFORD AMBULATORY SURGICAL CENTER

PLEASE COMPLETE AND BRING DAY OF PROCEDURE

Patient Account #_____ Date:_____

Primary Care Physician:_____

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:_____

Emergency Contact:

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:_____ ID#_____ Group# _____
Address:_____ Phone #_____
Subscriber:_____ SS#:_____ DOB:_____
Relationship:_____

Secondary Insurance: _____ 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 #_____

ADVANCE CARE DIRECTIVE INFORMATION:

Did you receive a copy of the BASC Advanced Directive policy? ___ Yes ___ No

Did you read and understand the contents of the policy? ___Yes ___No

If no to any of the above, please call our office at 603-622-3670.

Do you have a living will? ___ Yes ___ No

Do you have a durable power of attorney for healthcare? ___ Yes ___ No

Please provide the names and addresses of the people 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 number.

Name_____Address_____

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 BASC to use my patient information for quality and peer review.

I authorize BEDFORD Ambulatory Surgical Center (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 for 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_____