Andover Ambulatory Surgery Center

1124 West 21st Street, Suite 100
Andover, KS 67002
Phone: 316-440-3200
Fax: 316-440-3255

PATIENT REGISTRATION FORM

Date:_____ Referring Doctor: _____

PATIENT

Last Name	First		MI	❑ Male ❑ Female	Marital Status
Address		City		St	Zip
Home Phone	Cell Phone	Work Phone		Language Preference	
Social Security	Date of Birth		Email Address		
Employer	Employment Status: (circle one)	Full-time Part-time Other:_____		Occupation	
Employer Address		City		St	Zip
Emergency Contact **NAME, PHONE, RELATIONSHIP**				Primary Care Physician	

RESPONSIBLE PARTY

Last Name	First		MI	❑ Male ❑ Female	Marital Status
Address (if different)		City		St	Zip
Home Phone	Cell Phone	Work Phone		Relationship to Patient: ❑ Parent ❑ Spouse ❑ Other:_____	
Social Security	Date of Birth				
Employer	Employment Status: (circle one)	Full-time Part-time Other:_____		Occupation	
Employer Address		City		St	Zip

PRIMARY INSURANCE

Primary Insurance Name	Relationship to Patient			Occupation
Insurance Policy Holder's Name (if different)		Insurance ID Number		Insurance Group Number
Social Security Number		Birth Date	Primary Phone	Work Phone
Employer		Employer Phone		Employment Status (circle one): Full-time Part-time Other:_____
Employer Address		City	State	Zip

SECONDARY INSURANCE

Secondary Insurance Name	Relationship to Patient			Occupation
Insurance Policy Holder's Name (if different)		Insurance ID Number		Insurance Group Number
Social Security Number		Birth Date	Primary Phone	Work Phone
Employer		Employer Phone		Employment Status (circle one): Full-time Part-time Other:_____
Employer Address		City	State	Zip

OFFICE POLICY: I understand and agree to the following rules set forth by Andover Ambulatory Surgery Center:

1) Payment is required at the time of service. If I cannot pay my co-payment, my appointment will be rescheduled.

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT:

I authorize treatment of the patient named above and agree to pay all fees and charges for such treatment. In the event that legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I agree to pay reasonable attorney's fees and such other costs as the court determines proper. I hereby assign all proceeds of insurance to this office (a copy of this assignment is as valid as the original). I authorize the release of all medical information necessary to process any claims on my behalf. I also request payment of medical and/or government benefits to this office.

Signature: _____ Date: _____