San Francisco Surgical Medical Group

Welcome to our office! We are committed to providing the best care possible. We encourage you to ask questions and communicate openly with us. Please assist us by providing the following information. All information is confidential and is only released with your consent.

PATIENT REGISTRATION FORM

DATE OF APPT:	**SPECIALIST:**		**REFERRING PHYSICIAN:**	
NAME:	**MRN:**	**DOB:**	**AGE:**	**SEX:**
ADDRESS:	*Street*	*City/State*	*Zip*	
SOCIAL SECURITY #:	**PRIMARY LANGUAGE:**	**EMAIL ADDRESS:**		
ETHNICITY/RACE ☐ Hispanic or Latino ☐ American Indian/Alaska Native ☐ Native Hawaiian ☐ Asian ☐ White ☐ Black or African American ☐ Other ☐ Decline		**MARITAL STATUS** ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Domestic Partner		
PHONE #: (Please circle)	*Primary: Home / Cell / Work*	*Secondary: Home / Cell / Work*	*Tertiary: Home / Cell / Work*	
EMPLOYER:		**OCCUPATION:**		
EMPLOYER ADDRESS:				

PHARMACY	EMERGENCY CONTACTS
PHARMACY NAME:	**CONTACT NAME:**
PHARMACY ADDRESS:	**CONTACT PHONE #:** (home / cell / work)
PHARMACY TELEPHONE #:	**RELATIONSHIP:**

Our office will bill your insurance. You are responsible for the deductible, share of cost, co-payment at time of visit, and any costs not a benefit of your plan. If you do not have insurance we would appreciate payment at the time of your visit. Our staff is available if you have any questions. I authorize payment of medical benefits be made directly to the physician provider for services rendered. I authorize my doctor to release any medical or other information necessary to the party who accepts assignment. I authorize use of information from this form to bill my insurance companies.

DATE ____________________ PATIENT SIGNATURE ____________________