EDWARD C. SUN, MD

BOARD CERTIFIED ORTHOPAEDIC SURGEON

ADULT AND PEDIATRIC SPINE SURGERY

PATIENT REGISTRATION FORMS

WELCOME! In order to properly serve you, we will need the following information. **PLEASE COMPLETE ALL FORMS.** *Thank you.*

Patient Information:

Last Name: ____________________ First Name: ____________________ Middle Initial: ______

Date of Birth: ____/____/____ Age: ________ Social Security Number: ______-_____-______

Mailing Address: ________________________ City: ______________ State: ____ Zip: ______

Home Phone: (____)_____-______ Cell Phone: (____)_____-______ Work Phone: (____)_____-______

Marital Status: ____________ Gender: ________ Email Address: ________________________

Referring Doctor: ______________________ Primary Doctor: ________________________

Preferred Pharmacy: ______________________ City: ____________ Phone: (____)_____-______

Emergency Contact:

Person to notify in case of emergency: ____

Home Phone: (____)_____-______ Cell Phone: (____)_____-______ Relationship to Patient: __________

Guarantor's Information (Person financially responsible for payment):

Name (first and last): ___________________________ Relationship to patient: ______________

Phone: (____)_____-______ Employer: ______________________ Occupation: ______________

Insurance Information:

Primary Insurance Company: ________________________________ Effective Date: ____/____/____

Subscriber's Name (first and last): ______________________________ D.O.B.: ____/____/____

Subscriber's Social Security Number: ______-_____-______ Relationship To Patient: ______________

Secondary Insurance Company: ________________________________ Effective Date: ____/____/____

Subscriber's Name (first and last): ______________________________ D.O.B.: ____/____/____

Subscriber's Social Security Number: ______-_____-______ Relationship To Patient: ______________

Assignments of Benefits – Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to EDWARD SUN, M.D., Inc. for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. In addition, I authorize the release of my records for peer review by physicians in order to ensure the highest quality of care is being provided to me.

Patient's Signature or Authorized Representative: ______________________________________

Print Name: ____ Date: ____/____/____