Roosevelt Surgical Associates, Inc
4040 Roosevelt Boulevard
Middletown, Ohio 45044
www.rooseveltsurgical.com

REGISTRATION FORM

Account #_____

(Patient) First Name	Middle	Last Name
Birthdate	Sex ☐ Male ☐ Female	SS #
Address_____City_____State_____Zip_____		
Phone #1_____ Phone #2_____		
Email Address:		
Employed ☐ **F**ull Time ☐ **P**art Time ☐ **R**etired ☐ **N**o	Student ☐ Full Time ☐ Part Time	
Employer Name	Employer Phone: ( ) Ext.	
Marital Status ☐ **M**arried ☐ **S**ingle ☐ **D**ivorced ☐ **W**idowed ☐ **L**egally Separated		
Ethnic Group ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Other		
Preferred Language Spoken ☐ English ☐ Spanish ☐ French ☐ German ☐ Chinese		
Race: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaskan Native ☐ Multiracial		
Smoking Status: ☐ Non Smoker ☐ Former Smoker ☐ Current Smoker		
(Responsible Party) Last Name	First Name	
Address	City ST Zip	
SS #	Phone ( )	
Do you have a copay? ☐ Yes $_____ ☐ No		
PRIMARY Insurance	**ID #**	**GP#**
Subscriber Name	Subscriber Employer	
Subscriber Sex ☐ M ☐ F	Birthdate	
Relationship to Patient ☐ Self ☐ Spouse ☐ Dependent ☐ Other		
SECONDARY Insurance Carrier Name	**ID #**	**GP#**
Subscriber Name	Subscriber Employer	
Subscriber Sex ☐ M ☐ F	Birthdate	
Relationship to Patient ☐ Self ☐ Spouse ☐ Dependent ☐ Other		
☐ Accident or Auto Accident	☐ Job Related Injury	Date of Injury: W/C Claim #:
Referring Dr:	Address	Phone
Family Dr:	Address	Phone
Emergency Contacts: Please list two different contacts		
Name:	Phone	Relationship
Name:	Phone	Relationship

I request that payment of authorized Medicare or other insurance company benefits be made to the above Medical Practice for any services rendered to me by that Physician Group. Regulations pertaining to Medicare assignment of benefits apply. I authorize the above Medical Practice to release to the centers for Medicare and Medicaid Services or any other insurance company any information needed for this insurance claim.

☐ I give permission to proper representative from Roosevelt Surgical Associates to release medical information regarding my medication condition to:

_____

The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I also acknowledge that I have received a copy of Roosevelt Surgical Associates' notice of privacy practices.

SIGNED_____DATE_____