

-IN COMPUTER _____ (initials) -PT RIGHTS -HIPAA -ALLERGY CHART NUMBER: _____

Geneva Woods Surgical Center

3730 Rhone Circle, Suite 100 Anchorage, AK 99508 PH- 907.562.4764 FAX- 907.561.8519

*****PLEASE FILL OUT COMPLETELY AND PLEASE PRINT NEATLY. THANK YOU!*****

DATE OF SURGERY:		ATTENDING PHYSICIAN:	
PATIENTS LEGAL LAST NAME		FIRST NAME	MIDDLE INITIAL
MAILING ADDRESS		CITY	STATE ZIP CODE
HOME PHONE NUMBER		CELL PHONE NUMBER	EMAIL ADDRESS
CHECK ONE: <input type="checkbox"/> -MALE <input type="checkbox"/> -FEMALE ETHNICITY: <input type="checkbox"/> -Hispanic or Latino <input type="checkbox"/> -Neither Hispanic nor Latino		RACE: <input type="checkbox"/> American Indian or Alaska Native [3] <input type="checkbox"/> Asian [4] <input type="checkbox"/> Black or African American [2] <input type="checkbox"/> Native Hawaiian or Other Pacific Islander [5] <input type="checkbox"/> White [1] <input type="checkbox"/> Other [6] <input type="checkbox"/> Unknown or Patient Refused [9]	
MARITAL STATUS: <input type="checkbox"/> -SINGLE <input type="checkbox"/> -MARRIED <input type="checkbox"/> -DIVORCED <input type="checkbox"/> -WIDOWED			
DATE OF BIRTH	AGE	SOCIAL SECURITY NUMBER	RELIGION
EMPLOYER	OCCUPATION		DRIVER'S LICENSE NUMBER

GUARANTOR #1 PARENT _____ SPOUSE/GUARANTOR _____ LEGAL GUARDIAN _____			PRIMARY INSURANCE	
NAME			INSURANCE COMPANY	
MAILING ADDRESS			POLICY HOLDER NAME	
CITY	STATE	ZIP CODE	RELATIONSHIP TO PATIENT	
HOME PHONE	CELL PHONE	EMAIL ADDRESS	POLICY NUMBER	
EMPLOYER	DATE OF BIRTH	SOCIAL SECURITY NUMBER	GROUP NUMBER	
GUARANTOR #2 PARENT _____ SPOUSE/GUARANTOR _____ LEGAL GUARDIAN _____			SECONDARY INSURANCE	
NAME			INSURANCE COMPANY	
MAILING ADDRESS			POLICY HOLDER NAME	
CITY	STATE	ZIP CODE	RELATIONSHIP TO PATIENT	
HOME PHONE	CELL PHONE	EMAIL ADDRESS	POLICY NUMBER	
EMPLOYER	DATE OF BIRTH	SOCIAL SECURITY NUMBER	GROUP NUMBER	

DID AN INJURY/ACCIDENT NECESSITATE SURGERY? -YES -NO | **IS THIS A WORKER'S COMPENSATION CLAIM?** -YES -NO

EMERGENCY CONTACT

EMERGENCY CONTACT PERSON		RELATIONSHIP
HOME PHONE NUMBER	CELL PHONE NUMBER	WORK PHONE NUMBER

IF YOU ARE FROM OUT OF TOWN, PLEASE FILL OUT THE FOLLOWING INFORMATION:

Contact Person	Contact Phone #	Hotel/Room# or Address while staying in Anchorage
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PLEASE WRITE THE NAME AND CONTACT PHONE NUMBER OF PERSON TAKING YOU HOME:

Name	Contact Phone#
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(Initial)_____ If you are to receive **GENERAL ANESTHESIA, MONITORED ANESTHESIA** or **SEDATIVE DRUGS**, you **MUST** have someone over the age of 18 years old to take you home after surgery. We **cannot** release you on your own. If you **do not** have someone to take you home, your surgery will be cancelled. We **recommend** that you have someone stay with you **overnight**. If you waive this recommendation, understand that there may be additional risks both from Anesthesia and Surgery.

BENEFITS, DISCLOSURES & FINANCIAL RESPONSIBILITY

PLEASE READ CAREFULLY AND SIGN BELOW:

I HAVE INITIALED AND UNDERSTAND THAT I WILL RECEIVE BILLING SEPARATELY FOR EACH OF THE FOLLOWING CHARGES:

- (Initial)_____ 1. FACILITY FEE (OPERATING ROOM)
- (Initial)_____ 2. SURGEON'S FEE
- (Initial)_____ 3. ANESTHESIOLOGIST FEE
- (Initial)_____ 4. PATHOLOGIST AND/OR LABORATORY FEES *(When applicable)*

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered. I authorize Geneva Woods Surgical Center to release medical records required by my insurance company(s) and to my referring physician. I authorize my insurance company(s) to pay benefits directly to Geneva Woods Surgical Center. I agree that a reproduced copy of this authorization will be as valid as the original. I understand I am responsible for any amount not covered by my insurance and any reasonable collection agency or attorney fees incurred. This information may be released to a collection agency and/or credit bureau in the event my bill is not paid in a timely manner.

AUTHORIZATIONS

BY SIGNING BELOW, I CERTIFY THAT I HAVE READ THE ABOVE STATEMENTS AND THE INFORMATION I HAVE PROVIDED IS ACCURATE:

Print Patient Name: _____

Patient (Adult) / Parent / Legal Guardian Signature

Date