Surgery Center of Kenai, LLC
100 Trading Bay Drive
Kenai, AK 99611

REGISTRATION FORM

(Please Print)

All minors under the age of 18 must be accompanied by a parent or legal guardian

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status: Single Mar Div Sep Wid

Is this your legal name? ☒ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Social Security no.:	Cell phone no.: ( )	Home phone no.: ( )

Residential Address:	City:	State:	ZIP Code:
Billing Address (**if different than residential**):	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Referred by:

Pharmacy of Choice:

INSURANCE INFORMATION

*****Please give a copy of your photo ID and Insurance card to Receptionist*****

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Birth date / /	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Surgery Center of Kenai, LLC. I understand that I am financially responsible for any balance. I also authorize Surgery Center of Kenai or insurance company to release any information required to process my claims.

I have had the opportunity to review Surgery Center of Kenai's Privacy policy, Patient Rights and Responsibilities, and information regarding an advance directive.

Patient/Guardian signature *Date*