CENTER FOR SPECIAL SURGERY
Pre-Registration Form

Your arrival time at the Surgery Center today: _____

Your scheduled procedure time today: _____

SURGEON:_____

NAME: _____
(last) (first) (middle)

ADDRESS: _____ _____
(street) (Apt/Lot #)

_____
(city, state, zip code)

Do you currently live in a nursing home? Yes_____ No _____

HOME PHONE: _____WORK PHONE: _____
CELL PHONE: _____ FAX NUMBER: _____
EMPLOYER: _____
SEX: M _____ F _____ DATE OF BIRTH: _____
SOCIAL SECURITY #:_____
MARITAL STATUS: M____ S ____ D ____ W ____ SEP____
NATIONALITY: HISPANIC OR LATINO _____
NON-HISPANIC OR LATINO _____
EMAIL ADDRESS (optional): _____

Insurance:
Policy Holder (if not the patient): _____
Date of Birth: _____

IMPORTANT

We want to make sure that you understand every part of your care today. If you can read and understand this message, please sign this registration form, hand it back to the receptionist, and state your name.

_____ _____
(Signature) (Today's date)