SOUTH PORTLAND
SURGICAL
CENTER
6370 SW Borland Rd., Suite 100
Tualatin, Oregon 97062
503.218.1105

REGISTRATION FORM

Date _____

Last Name _____ First Name _____ MI _____

Address _____
(Street) (City) (State) (Zip)

Home Phone _____ Cell Phone _____ Work Phone _____

Best time to call _____ Date of Birth _____ Marital Status M S W

SSN _____ Employer _____ Occupation _____

Email Address _____ Name of escort/person accompanying you _____

In case of emergency, contact:

Name _____ Relationship _____

Daytime Phone # _____ Cell Phone # _____

Responsible Party (if not patient):

Last Name _____ First Name _____ MI _____

Address _____
(Street) (City) (State) (Zip)

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____

Insurance Information (please fill out COMPLETELY):

Primary Insurance _____ ID# _____ Group # _____

Subscriber _____ DOB/Subscriber _____

Relationship to patient _____ Employer _____

Secondary Insurance _____ ID# _____ Group # _____

Subscriber _____ DOB _____

Relationship to patient _____ Employer _____

Workers Compensation / L&I Information (please fill out COMPLETELY):

Employer Name where injury occurred _____

Address _____
(Street) (City) (State) (Zip)

Work Phone # _____ Workers Comp Insurance Company _____

Address _____
(Street) (City) (State) (Zip)

Phone #_____ Date of Injury _____ Claim# _____

Motor Vehicle Accident / Third Party Liability / Lawsuit (please fill out COMPLETELY):

Insurance Company _____

Address _____
(Street) (City) (State) (Zip)

Phone # _____ Name of Subscriber to Policy _____

Claim # _____ Date of Accident _____

Name of Attorney _____ Phone # _____

Address of Attorney _____
(Street) (City) (State) (Zip)

If other, address to send claim to _____

Release of Information and Conditions of Admission
(patient initial by each consent)

Initials

_____ **1. Release of Information**
I hereby authorize SPSC, LLC to provide all of the patient's recorded information included in the medical record to the patient's insurance company.

_____ **2. Transfer of Information**
I hereby consent to the release and transfer of records in the unlikely event it becomes medically necessary for transfer of patient to hospital while in the care of SPSC, LLC. I further consent to the release of the hospital discharge records to SPSC, LLC upon discharge from the hospital.

_____ **3. Authorized Personnel/Imaging**
I hereby authorize any personnel previously approved by my surgeon and SPSC, LLC management to be in the operating room. I consent to imaging in the event it is necessary, of my person or portion of my body or organs being taken during my procedure by my physician or a designee approved by my physician for the purpose of medical treatment. I consent that these images will become a part of my medical record.

_____ **4. Authorized Research/Education**
I hereby authorize to the use of my medical records for the purpose for research/education, provided my identity is not revealed or any descriptive texts accompanies them.

_____ **5. Assignment of Benefits**
I hereby authorize my Insurance company to make payment directly to South Portland Surgical Center, LLC for the medical and surgical benefits allowable and otherwise payable to me under the current insurance policy. I have received a copy of the Patient Financial Responsibility agreement.

_____ _____ _____
Patient/Parent/Guardian Signature (indicate) Date Time

Patient is unable to sign because: _____

Authorized Witness: _____

Oregon State Reporting Requirement: Please check the box(s) that are applicable:

- ❑ American Indian or Alaska Native
- ❑ Asian
- ❑ Black or African American
- ❑ Native Hawaiian or Pacific Islander
- ❑ White
- ❑ Other

- ❑ Hispanic or Latino Ethnicity
- ❑ Non Hispanic or Latino Ethnicity
- ❑ I decline to answer

_____
Patient/Parent/Guardian Signature (indicate)