PHYSICIANS SURGERY CENTER
of
Frederick

REGISTRATION FORM

Patient Information

Name: ____ Today's Date: __________________________________
Address: ____City:_______________State:_________Zip________________
Phone (______) __________________ Work Phone (_____) ________________ Cell Phone (______)___________________
Date of Birth: _____________________ Social Security Number: ___________________________
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School________________________________ City/State______________________________ ☐ FT ☐ PT
Employer____ Employer Phone__________________________
Employer Address ____
Full Time □ Part Time □ Retired □ Not Employed □

If the responsible party is the same as above (the patient), please check "SELF" and proceed to the next section, Insurance Information.

Responsible Party

Patient Relationship to Responsible Party: ☐ Self ☐ Spouse ☐ Child ☐ Other ________________________
Name: ____
Address: ____City:_______________State:_________Zip________________
Phone (______) __________________ Work Phone (_____) ________________ Cell Phone (______)___________________
Date of Birth: _____________________ Social Security Number: ___________________________
Employer____ Employer Phone________________________
Employer Address ____
Full Time □ Part Time □ Retired □ Not Employed □

Insurance Information

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ________________________
Name of Insured____
Insured Date of Birth: _____________________ Insured Social Security Number:___________________________
Employer____ Employer Phone__________________________
Employer Address ____
Full Time □ Part Time □ Retired □ Not Employed □
Insurance Company______________________________ Group #_____________________ ID#___________________________
ADDTIONAL INSURANCE:
Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ________________________
Name of Insured____
Insured Date of Birth: _____________________ Insured Social Security Number:___________________________
Employer____ Employer Phone__________________________
Employer Address ____
Full Time □ Part Time □ Retired □ Not Employed □
Insurance Company______________________________ Group #_____________________ ID#___________________________

Anesthesia services are billed separately by First Colonies Anesthesia. Pathology services are billed separately by HCT Pathology Services or Frederick Memorial Hospital.