



Bay Area Breast Surgeons, Inc.  
A Partnership for Breast Health

DATE: \_\_\_\_\_

### PATIENT REGISTRATION INFORMATION

**\* In order to bill your Insurance properly, Please PRINT and complete ALL sections below.\***

#### PATIENT PERSONAL INFORMATION:

**Marital Status**  Single  Married  Divorce  Widowed  Domestic Partner

Name: \_\_\_\_\_ Sex: Male / Female  
Last Name First Name Middle

Address \_\_\_\_\_ (Apt.# \_\_\_\_\_) City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Driver's License # \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell/Mobile #: \_\_\_\_\_ Other #: \_\_\_\_\_

Work # \_\_\_\_\_ E-mail: \_\_\_\_\_

May leave message with:  HOME  WORK  CELL PHONE  NONE

How would you like to be addressed? \_\_\_\_\_

Employer: \_\_\_\_\_

Spouse or Partner's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Employer: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

**REFERRING DOCTOR:** \_\_\_\_\_

**PRIMARY PHYSICIAN & OTHER DOCTORS WHO CARE FOR YOU:** \_\_\_\_\_

#### **EMERGENCY CONTACT:**

Name \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

#### **INDIVIDUAL RESPONSIBLE FOR PAYMENT**

Name \_\_\_\_\_ Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_

Address \_\_\_\_\_ Phone #: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Parent  Other \_\_\_\_\_

#### **PRIMARY INSURANCE COMPANY**

Insurance Company Name \_\_\_\_\_ Insurance ID# \_\_\_\_\_

Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_ Group #: \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Parent  Other \_\_\_\_\_

#### **SECONDARY INSURANCE COMPANY**

Insurance Company Name \_\_\_\_\_ Insurance ID #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ DOB: \_\_\_\_\_ Group #: \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Parent  Other \_\_\_\_\_

(CONTINUED ON BACK)

ASSIGNMENT OF BENEFITS • FINANCIAL AGREEMENT

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Lisa Bailey / Jon Greif/Lana Louie, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize Bay Area Breast Surgeons, Inc to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_