

**SEQUOIA SURGICAL PAVILION - REGISTRATION FORM**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_  
State/ZIP \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Social Security Number \_\_\_\_\_ Financial Responsible Party: \_\_\_\_\_  
Employer: \_\_\_\_\_ **Auto or Worker's comp related?** \_\_\_\_\_

**IF YES - Skip to WC section. IF NO - Complete the following Insurance Section:**

**PRIMARY INSURANCE: Bolded Items MUST be completed by Responsible Party**

**Subscriber's Name:** \_\_\_\_\_ **Sub DOB:** \_\_\_\_\_  
**Subscribers ID#:** \_\_\_\_\_ **Pt's relation to insured:** \_\_\_\_\_  
Group #: \_\_\_\_\_ Group Name: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
Carrier: \_\_\_\_\_ Carrier Phone #: \_\_\_\_\_ Sub Employer: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_

**SECONDARY INSURANCE: Bolded Items MUST be completed by Responsible Party**

**Subscriber's Name:** \_\_\_\_\_ **Sub DOB:** \_\_\_\_\_  
**Subscribers ID#:** \_\_\_\_\_ **Pt's relation to insured:** \_\_\_\_\_  
Group #: \_\_\_\_\_ Group Name: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
Carrier: \_\_\_\_\_ Carrier Phone #: \_\_\_\_\_ Sub Employer: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_

<p><b>WORKER'S COMP or AUTO CLAIM NUMBER:</b> _____</p> <p><b>Date of injury</b> _____ <b>Adjustor's Name:</b> _____</p> <p><b>Carrier Name</b> _____ <b>Carrier Phone #</b> _____</p> <p><b>Carrier Address</b> _____</p>
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I \_\_\_\_\_ verify that all of the above information is accurate.

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_