

Day Surgery

Patient Registration Form



Please complete this form and return it to Rapides Regional Medical Center, 211 Fourth Street, Alexandria, LA 71301, Attn: Pre-Admission Testing. Or you may fax it to (318) 769-3899. When you arrive for your scheduled surgery, please bring your insurance cards with you so that we can verify your coverage. Thank you for your cooperation.

Patient Last Name _____ First _____ M.I. _____

Surgery Date ____/____/____ Surgeon _____ Anes. Type _____

Procedure(s) _____

M/F _____ Marital Status _____ DOB ____/____/____ SSN ____-____-____ Driver's Lic. _____

Home Phone _____ Pt. Address _____

Work Phone _____

Cell Phone _____

Emergency Phone _____ Name & Relationship to Patient _____

Employment (F/P/R/N) _____ Student (F/P/N) _____ Employer/Occupation _____

IF PATIENT IS UNDER 18, PLEASE COMPLETE THE FOLLOWING:

Resp. Party _____ M/F _____ DOB ____/____/____

Relationship to Patient _____ Responsible Party SSN ____-____-____

Address _____ Phone _____

Employer/Occupation _____

Primary Insurance

Secondary Insurance

Company _____

Address _____

Phone _____

ID/SSN _____

Policy/Group _____

Authorization _____

Group Plan Name _____

Subscriber Name _____

DOB & Relation ____/____/____

____/____/____

Employer/Occupation _____

Accident (Y/N) ____ Date of Injury ____/____/____ Location (State) _____ Employment Related (Y/N) ____

Automobile (Y/N) ____ Claim No. _____ Attention _____

Additional procedures may be necessary as above procedure(s) is/are being performed. Have you been informed of this and possible related additional charges? ____ Yes ____ No Initials ____

Previous Admit to RRMC (Y / N)