

**WESLEY WOODS GERIATRIC HOSPITAL
OUTPATIENT REGISTRATION**

<u>PATINET INFORMATION</u>						
NAME	LAST	FIRST	MIDDLE	MAIDEN NAME		
ADDRESS		CITY	STATE	COUNTY	ZIP	HOME PHONE ()
DATE OF BIRTH	AGE	RACE	SEX	PLACE OF BIRTH	MARITAL STATUS	SOC. SEC. NUMBER
SPOUSE		EMPLOYER			BUSINESS PHONE ()	
<u>PERSON RESPONSIBLE FOR BILL (OMIT IF SAME AS PATIENT INFORMATION)</u>						
NAME	LAST	FIRST	MIDDLE	MAIDEN NAME		
ADDRESS		CITY	STATE	COUNTY	ZIP	HOME PHONE ()
DATE OF BIRTH	AGE	RACE	SEX	PLACE OF BIRTH	MARITAL STATUS	SOC. SEC. NUMBER
EMPLOYER					BUSINESS PHONE ()	
<u>NEAREST RELATIVE OR OTHER EMERGENCY CONTACT</u>						
NAME	LAST	FIRST	MIDDLE	RELATIONSHIP TO PATIENT		
ADDRESS		CITY	STATE	ZIP	BUSINESS PHONE ()	HOME PHONE ()
<p>MEDICAL AND SURGICAL CONSENT: The patient is under the care and supervision of his/her attending physician and it is the responsibility of the hospital and its nursing staff to carry out the instructions of such physician; the undersigned recognizes that some physicians furnishing services to the patient, including the radiologist, pathologist and the like, are independent contractors and are not employees or agents of the hospital. The undersigned consents to x-ray examination, laboratory procedures, medical treatment or hospital services rendered the patient under general and special instructions of the physician.</p> <p>DATE: _____ SIGNATURE: _____</p>						

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the Wesley Woods Geriatric Hospital to release medical information to my referring physician and any insurance company with whom I have medical or surgical benefits for the purpose of filing a medical or surgical claim.

DATE: _____ **SIGNATURE:** _____

ASSIGNMENT OF BENEFITS

I authorize my health insurance benefit plan to pay directly to the Wesley Woods Geriatric Hospital the medical/surgical benefits otherwise payable to me.

DATE: _____ **SIGNATURE:** _____

MEDICARE LIFE-TIME CLAIM AUTHORIZATION

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

DATE: _____ **SIGNATURE:** _____