Winfield Surgery & Services

CHRISTOPHER A. MORRISSEY, DO
GENERAL SURGERY

PATIENT REGISTRATION

PATIENT	INSURANCE POLICY HOLDER
Last Name:	Last Name:
First Name: Initial:	First Name:
Date of Birth:	Address:
Social Security #:	City: State: Zip:
Address:	Home Phone:
City: State: Zip:	Work Phone:
Home Phone:	Cell Phone:
Work Phone:	Sex: Date of Birth:
Cell Phone:	Social Security #:
Email Address:	Employer:
Marital Status:	PRIMARY INSURANCE
Who referred you to our practice:	Insurance Company Name:
Who is your primary physician:	Name of insured person:
Employer:	Insurance ID #:
(Check one) ☐ Full-time ☐ Part-time ☐ Self ☐ Disabled ☐ Unemployed ☐ Retired ☐ Military	Group Number #:
EMERGENCY CONTACT INFORMATION	SECONDARY INSURANCE
Name:	Insurance Company Name:
Home Phone:	Name of Insured Person:
Work Phone:	Insurance ID #:
Cell Phone:	Group #:

Which Pharmacy do you prefer?

Pharmacy	**Phone #**

Assignment and Financial Responsibility

I hereby assign payment directly to Winfield Surgery & Services for surgical and/or medical benefits. I acknowledge that I accept full responsibility for any medical service rendered to me or anyone for whom I am legally responsible for. I understand I am financially responsible for charges even when insurance should provide coverage and does not pay a valid claim within 90 days, or for non-covered services. I will be legally responsible for all collection costs involved with this account including all return check fees, court costs, attorney fees and other expenses incurred with collection if I default on this agreement. **I have received a copy of the WSS Payment Policy and agree to its terms. I acknowledge that the Notice of Privacy Practices of Winfield Surgery & Services have been offered to me and available upon request at any time.**

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Patient Signature (or Guarantor if Minor) **Date**

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Patient Name Printed