MISSION SURGERY CENTER

Affiliated with Mission Hospital Regional Medical Center

Dear Patient:

In order to better serve you, we would like to assist you in facilitating the registration process and financial arrangements for your upcoming surgery. Please complete the information and return to us as soon as possible. If you should have any questions, please do not hesitate to call our Patient Registration department at 949-364-2201.

PATIENT INFORMATION

Patient's Full Name: _____

Social Security Number:_____ Date of Birth:_____/_____/_____ Home Phone:_(___)_____

Street Address: _____

City:_____ State:_____ Zip Code:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

INSURANCE

INSURANCE NO 1:_____
Insurance Company Name

Insured's Name: _____

Subscribers SS#:_____

Relation to Patient: _____

Subscribers Date of Birth:_____

Insured's Employer Name: _____

Telephone No.: _____

Occupation: _____

INSURANCE NO 2:_____
Insurance Company Name

Insured's Name: _____

Subscribers SS#:_____

Relation to Patient: _____

Subscribers Date of Birth:_____

Insured's Employer Name: _____

Telephone No.: _____

Occupation: _____

HAVE YOU HAD SURGERY AT THIS FACILITY? _____ IF YES WHEN _____

IF YOU HAVE AN HMO, PLEASE OBTAIN A COPY OF THE TREATMENT AUTHORIZATION FROM YOUR PHYSICIAN OR INSURANCE CARRIER FOR US TO SUBMIT WITH YOUR BILL.

PATIENT EMPLOYMENT

Patient's Employer's Name:_____

Street Address: _____

City:_____ Employer's Telephone No.: (____)_____

State:_____ Zip:_____ Occupation: _____

EMERGENCY CONTACT: List the person who will be transporting you home after surgery.

Name: _____

Home Phone: (_____) _____ Work Phone: (_____) _____