



WESTFALL SURGERY CENTER, LLP

1065 Senator Keating Blvd.
Rochester, NY 14618-2673
(585) 256-1330
FAX (585) 256-3735

PATIENT PRE-REGISTRATION INFORMATION

Medical Record No. _____

Date of Surgery _____

PLEASE COMPLETE AND RETURN TO THE ABOVE ADDRESS.

PATIENT'S PERSONAL DATA

Is this your first appointment at Westfall Surgery Center? [] YES [] NO

Patient's Name (Last, First, MI) Date of Birth

Social Security Number Sex [] Male [] Female Race* [] Caucasian [] African-American [] Native-American [] Asian [] Hispanic [] Other Marital Status [] Single [] Married [] Widow/Widower [] Divorced

Patient Address (No., Street, Apt.) Home Phone

City, State, Zip Work Phone

Private (Family) Physician Address Telephone

Notify in Case of Emergency Phone#

Relationship Address

PRIMARY MEDICAL INSURANCE

Primary Insurance Address

Policy I.D. No. Group Name Group Number

Name of Subscriber Address of Subscriber Date of Birth Relationship

Insured's Employer Name & Address

SECONDARY MEDICAL INSURANCE

Secondary Insurance Address

Policy I.D. No. Group Name Group Number

Name of Subscriber Address of Subscriber Date of Birth Relationship

Insured's Employer Name & Address

RESPONSIBLE PARTY INFORMATION

Last Name, First, MI Relationship

Address

Employer's Name and Address

Please contact the billing office between 8:00 AM - 5:00 PM at 256-3864 if you have any questions regarding insurance information.

* Required for New York State Department of Health registry purposes.