- ❑ Harbourside Cardiology
- ❑ Harbourside OBGYN
- ❑ Harbourside Surgery
- ❑ 17 Davis Pediatrics
- ❑ 17 Davis OBGYN
- ❑ Pediatric Child Development
- ❑ Pediatric Genetics
- ❑ Eye Institute
- ❑ Other:_____

USF HEALTH
USF Physicians Group

NP Reg ____ EP Update ____
Chart Made: ❑ Yes ❑ No

PATIENT REGISTRATION FORM

Please complete both sides in full

Medical Record # _____

Patient Name: _____
Last First Middle Initial

Social Security #: _____

Sex: _____ Date of Birth: _____ Marital Status: _____ Race: _____

Street Address: _____ Apt #: _____

City, State, Zip Code: _____

Telephone #: Area Code ( ) _____

Patient's Employer: _____

Address _____

City, State, Zip Code: _____

Business Phone: Area Code ( ) _____

Responsible Party Information if Patient is a Minor

Name of Responsible Party: _____
Last First Middle Initial

Social Security #: _____

Street Address: _____ Apt #: _____

City, State, Zip Code: _____

Telephone #: Area Code ( ) _____

Responsible Party Employer: _____

Address _____

City, State, Zip Code: _____

Business Phone: Area Code ( ) _____

In Case of Emergency Contact:

Name: _____ Telephone #: Area Code ( ) _____

Additional Home Address Information:

Street Address: _____

City, State, Zip Code: _____

Insurance Information - (Please indicate if Managed Care ☐ Yes ☐ No)

Primary: Effective Date _____

Carrier Name: _____

Benefit Verification Telephone Number: _____

Claims Processing Address: _____

City, State, Zip Code: _____

Authorization Number and/or Name of Person Authorizing

Billing for Treatment: _____

Subscriber Name: _____

Sex: ____ M ____ F Date of Birth: _____

Social Security Number: _____

Street Address: _____ Apt. #: ____

City, State, Zip Code: _____

Employer: _____

Patient Relationship to Subscriber:

☐ Self ☐ Spouse ☐ Dependent Child ☐ Student ☐ Other

Certificate or Policy #: _____

Group #: _____ Plan #: _____

Insurance Information - (Please indicate if Managed Care ☐ Yes ☐ No)

Primary: Effective Date _____

Carrier Name: _____

Benefit Verification Telephone Number: _____

Claims Processing Address: _____

City, State, Zip Code: _____

Authorization Number and/or Name of Person Authorizing

Billing for Treatment: _____

Subscriber Name: _____

Sex: ____ M ____ F Date of Birth: _____

Social Security Number: _____

Street Address: _____ Apt. #: ____

City, State, Zip Code: _____

Employer: _____

Patient Relationship to Subscriber:

☐ Self ☐ Spouse ☐ Dependent Child ☐ Student ☐ Other

Certificate or Policy #: _____

Group #: _____ Plan #: _____

Is this visit due to an Accident/Injury: Yes _____ No _____

If Yes, Date of Injury: _____

Employer at Time of Injury: _____

Referring Physician

Name: _____

Street Address _____

City, State, Zip Code _____

Phone #: _____

And/Or Primary Physician

Name: _____

Street Address _____

City, State, Zip Code _____

Phone #: _____

Permission for Treatment and Authorization for Assignment of Insurance Benefits

☐ Permission is hereby granted to the USF Medical Center, USF Endoscopy and Surgery Center, and/or Satellite Locations to render such medical and surgical treatment as is deemed necessary.

☐ Authorization is given to the USF Medical Center, USF Endoscopy and Surgery Center, and/or Satellite Locations to release any information including examination, diagnosis and treatment, to my insurance carrier. I request my insurance carrier to pay the USF Medical Center, USF Endoscopy and Surgery Center, and/or Satellite Locations all benefits due me related to my pending claim for medical and surgical services.

X _____ _____

Signature of Insured / Guardian Date