



**SAINT BARNABAS**  
**AMBULATORY SURGERY CENTER**  
 200 SOUTH ORANGE AVENUE LIVINGSTON, NJ 07039  
 Tel: 973-322-7700 Fax: 973-322-7397

**PATIENT REGISTRATION FORM**

**PLEASE BRING THIS FORM WITH YOU ON THE DAY OF SURGERY**

PATIENT INFORMATION				
PATIENT NAME	DATE OF SURGERY	HOME PHONE	SOCIAL SECURITY #	
STREET ADDRESS	DATE OF BIRTH	WORK PHONE	MARITAL STATUS	SEX
CITY, STATE, ZIP CODE	EMERGENCY CONTACT/RELATIONSHIP TO PATIENT		PHONE	
EMPLOYER-NAME, ADDRESS, CITY, STATE, ZIP CODE			PHONE	

PRIMARY INSURED'S INFORMATION			
NAME	HOME PHONE	WORK PHONE	SOCIAL SECURITY #
STREET ADDRESS-CITY, STATE, ZIP CODE			
EMPLOYER-NAME, ADDRESS, CITY, STATE, ZIP CODE			DATE OF BIRTH

INSURANCE INFORMATION			
PRIMARY INSURANCE		PRIMARY INSURANCE	
BILLING ADDRESS		BILLING ADDRESS	
CITY, STATE, ZIP CODE		CITY, STATE, ZIP CODE	
INSURED'S NAME	PHONE #	INSURED'S NAME	PHONE #
PATIENT'S RELATIONSHIP TO INSURED	DATE OF BIRTH	PATIENT'S RELATIONSHIP TO INSURED	DATE OF BIRTH
GROUP NAME	GROUP #	SOCIAL SECURITY #	GROUP #
INSURED'S ID #	PRE-CERTIFICATION #	INSURED'S ID #	PRE-CERTIFICATION #
EMPLOYER NAME		EMPLOYER NAME	
EMPLOYER ADDRESS		EMPLOYER ADDRESS	
DATE/TIME OF ACCIDENT	CLAIM #	ADJUSTER	

**I hereby certify that:**

1. I am financially responsible for the patient named above and attest that the information provided is correct.
2. I authorize Saint Barnabas Ambulatory Surgery Center to submit claims for medical benefits to which I am entitled to insurance companies, governmental agencies and others and authorize that such benefits be paid directly to the provider; and I authorize release of all records required to act on this request.
3. I understand that I am responsible for charges not paid by insurance or not covered by this assignment.

\_\_\_\_\_  
SIGNATURE OF RESPONSIBLE PARTY

\_\_\_\_\_  
DATE

\_\_\_\_\_  
RELATIONSHIP TO PATIENT