FAMILY SURGICAL SOLUTIONS, L.L.C
8127 Merrillville Road, St 3, Merrillville, IN 46410

****PATIENT REGISTRATION – ALL SECTIONS NEED TO BE COMPLETED****

PATIENT NAME: First_____Middle_____Last_____

Address_____City_____St_____Zip_____Birthdate_____Age____

Sex: M__F__ Marital Status: S__M__D__W__ Dr. who referred you?_____

PHONE #'S HOME_____Cell #_____Work #_____

Employment Status: Full____Part-time__ Employer:_____Phone_____

College Student__Full__Pt___ Unemployed___ Email_____

EMERGENCY CONTACT PERSONS (Not living with Patient)

Name_____Relationship_____Phone #'s: Home_____Cell_____Work_____

SPOUSES INFORMATION

NAME_____ Phone#'s: Home_____Cell_____Work_____Employer_____

Address of Employer_____City/State_____Employer Phone_____

RESPONSIBLE PERSON IF PATIENT IS A MINOR/CHILD

Name_____Birthdate_____Address_____

Phone #s: Home_____Cell_____Employer: _____Phone_____

NO SHOW POLICY!

Each time a patient misses an appointment without providing a proper notice, another patient is prevented from receiving care. We reserve the right to charge for these occurrences. Due to the high patient demand, and limited availability of appointment, we have instituted a

$35.00 NO SHOW FEE

You must give a 24 hour advanced notice to cancel your appointment. Failure to do so will result in a $35.00 fee charged to you. By signing below, I acknowledge that I have read and understand this policy.

Patient Name (Print)_____**Patient Signature**_____

AUTHORIZATION TO PAY BENEFIT

I certify that the above information is true and accurate. I authorize Medical Surgical Wellness Center, LLC. the Release of any medical or non-medical information regarding services rendered to me or my dependent by Dr. Dennis L. Streeter. I authorize the assignment of all insurance benefits and understand that I am responsible for the payment of all services not paid by my insurance or other benefits. I further understand that should I default in payment, that I am responsible for any and all collections, costs and/or attorney fees incurred.

PATIENT/LEGAL GUARDIAN/REPRESENTATIVE SIGNATURE_____DATE_____

Family Surgical Solutions, L.L.C.

Dr. Dennis Streeter, D.O., F.A.A.O.S.

8127 Merrillville Rd. Ste 3.

Merrillville, IN 46410

By signing below, I _____ acknowledge that I have received the Notice of Privacy Practices from Family Surgical Solutions.

Signature: _____ Date: _____

If not signed by patient, please indicate your relationship to the patient.

Relationship: _____ Witnessed by: _____

I am also giving my permission for my medical information to be released and discussed with the following people:

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____