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
Employer		Address	
Private (Family) Physician			
Notify in Case of Emergency		Phone #	Relationship

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.