Registration Form
(Please Print & Complete Entire Form)

Surgical Associates of Dallas

621 N. Hall, Ste. 520
Dallas, TX 75226

Hassan I. Bukhari, MD _____
Rizwan H. Bukhari, MD _____
Jay Vasquez, Jr., MD _____
Hung B. Chu, MD _____

Date _____ **Home Phone (____)** _____ **Cell (____)** _____

PATIENT INFORMATION

Name _____ **SS#** _____
Last Name First Name Middle Initial

Address _____

City _____ **State** _____ **Zip** _____

Sex ☐ **M** ☐ **F** **Age** _____ **Birthdate** _____ ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed**

Ref Dr _____ **Ref Dr Ph** _____

Patient Employer/School _____ **Occupation** _____

Employer/School Address _____ **Employer/School Phone (____)** _____

Spouse Name _____ **DOB** _____ **SS#** _____

Spouse Employer _____ **Spouse Emp Ph** _____ **Spouse Cell** _____

Emergency Contact _____ **Emergency Contact Ph** _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ **Birthdate** _____ **Soc. Sec. #** _____

Address (If different from patient's) _____ **Phone (____)** _____

City _____ **State** _____ **Zip** _____

Person Responsible Employed by _____ **Occupation** _____

Business Address _____ **Business Phone (____)** _____

Insurance Company _____

Contract # _____ **Group #** _____ **Subscriber #** _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ **Yes** ☐ **No**

Subscriber Name _____ **Birthdate** _____ **Relation to Patient** _____

Address (If different from patient's) _____ **Phone (____)** _____

City _____ **State** _____ **Zip** _____

Subscriber Employed by _____ **Business Phone (____)** _____

Insurance Company _____ **Soc. Sec. #** _____

Contract # _____ **Group #** _____ **Subscriber #** _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company

Dr. _____ all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end whom my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relation to Patient