

**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