

**MANATEE**  
**surgical**  
**specialists**

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*A. Samir Hassan M.D., F.A.C.S. General and Vascular Surgery*

**PATIENT REGISTRATION**

Patient Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_

Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  Male   
Female

Local Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Other Address: \_\_\_\_\_  
Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Marital Status:  Married  Single  Divorced   
Widowed

Place of Employment: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
\_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
\_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about our office?  Referred by physician  Newspaper Ad  Phone Book  
 Website  Family/Friend

**Insurance Information:**

Primary Insurance: \_\_\_\_\_  
\_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary Insurance:

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Authorization / Medicare Assignment:

I hereby authorize Manatee Surgical Specialists to furnish information to insurance carriers concerning my illness and treatment. I hereby assign to the physician all payments for medical services rendered to myself or dependent.

\_\_\_\_\_  
Patient / Legal Guardian Signature

\_\_\_\_\_  
Date