Completing Your Online Patient Pre-Registration

Safety Harbor Surgery Center
3280 N. McMullen Booth Road, Suite 110, Clearwater, FL 33761
(727) 787-3000

Safety Harbor Surgery Center offers patients the convenience and privacy of a secure, online registration process. If you are a new patient to our center, please go online today to complete your registration using the login information below. You will be asked about your health history, medications, and previous surgeries. It's important to complete your online registration as soon as possible so that your medical team will have time to review your information prior to your visit. We will call you if we have any questions or concerns.

You will be receiving an automated recorded message from Simple Admit when your appointment is scheduled. If you are unable to understand or write down the information from this message please call (727) 787-3000.

Here are the simple steps for completing the online pre-visit medical screening and registration form:

1. Go online to www. safetyharborsurgerycenter.com.
2. Select "Simple Admit" on left side of home page.
3. Scroll to the middle of the page and enter the following password: SHSC727NEW
4. Please review our policies and enter your medical history as soon as possible.

IF THIS IS YOUR FIRST VISIT TO SAFETY HARBOR SURGERY CENTER OR IT HAS BEEN LONGER THAN A YEAR SINCE YOUR LAST VISIT YOU WILL NEED TO COMPLETE THE PRE-VISIT MEDICAL SCREENING AND REGISTRATION ONLINE WITH ANY COMPUTER, TABLET OR SMART PHONE.

If you are unable to go online please fill out your Guest Registration Packet and contact our pre admission testing nurse at (727)787-3000. Please have your medical history information available to assist the nurse with your medical screening. Thank you in advance for completing your online registration. This information will help us give you the best medical care possible. We look forward to seeing you soon!

Guest Registration Information

Have you ever been a patient at the Safety Harbor Surgery Center in the past? YES NO

Patient Name: _____ _____ _____
Last First M.I.

Date of Birth: _____ Soc. Security Number: _____ Male Female

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Complete Address: _____

_____ Home Phone # ( ) _____
City, State, ZIP

Cellular Phone # ( ) _____ Work Phone # ( ) _____

Email: _____ (This will only be used for your online patient satisfaction survey)

Race: (circle one) Black White Asian Hispanic Other _____

(For our female guests)
Is there a chance that you may be pregnant? YES NO
Last menstruation Period _____ Estimated Due Date _____

**** GUARANTOR INFO (ONLY complete if the patient is a minor (under 18 yrs) or incapacitated adult)****

Name of Guarantor _____ Soc Security # _____

Guarantor's Date of Birth _____ Relationship to patient _____

Address (**only** if different than patient) _____

_____ Home Phone # ( ) _____
City, State, Zip

**** INSURANCE SUBSCRIBER INFO (complete ONLY if sub on the insurance policy is not the patient)****
AName of Subscriber _____ Soc. Security # _____

Relationship to Guarantor ____ Spouse ____ Parent ____ Other Date of Birth _____

**** ACCIDENT INFO (please complete if service we are providing to you today is the result of an accident)****

Worker's Comp _____ Auto Accident _____ Other _____

Date of Accident or Injury (day, month, year) _____ Claim # _____

Name of Insurance carrier, claims address, phone number and name of adjuster handling the claim:

_____

_____

Medicare Secondary Payer Questionnaire
(Short Form)

1. Are you receiving benefits from any of the following programs?

Black Lung	____No____Yes
Research Grant	____No____Yes
Veteran Affairs	____No____Yes

2. Was the illness/injury due to a work related accident/condition?

_____ No _____ Yes

Date of injury/illness: _____

3. Was illness/injury due to a non-work related accident?

_____ No _____ Yes

Date of accident: _____

What type of accident caused the illness/injury?
_____ Automobile
_____ Non-automobile

4. Are you entitled to Medicare based on:

_____ Age
_____ Disability
_____ End Stage Renal Disease

5. Are you currently employed?

_____ No _____ Yes

6. Is your spouse currently employed?

_____ No _____ Yes

7. Do you have group health plan (GHP) coverage based on your own, or a spouse's, current employment?

_____ No _____ Yes

8. Does the employer that sponsors your GHP employ 20 or more employees?

_____ No _____ Yes

9. Are you currently a patient in a skilled nursing facility such as a nursing home? (Long form not required. ALERT: If yes, bill SNF not Medicare)

_____No _____ Yes

I confirm that the above information is correct.

Patient Signature:_____ Date:_____

Please Print Name:_____