Center for Colon & Digestive Diseases

Patient Registration

Patient Information

Referring Physician:

Your Name: First (MI) Last	Birth Date: / /	☐ Male ☐ Female
Address: Street City State Zip		
Phone:	Email:	
May we text your appointment reminders? ☐Yes ☐No	Preferred Language:	
Race: ☐American Indian/Native Alaskan ☐White ☐Black/African American ☐Hispanic/Latino ☐Native Hawaiian/Pacific Islander ☐Asian ☐Other		
Occupation:	Employer:	

Emergency Contact

☐I authorize Center for Colon & Digestive Diseases to release health information to my Emergency Contact

Name:	Relationship	Phone:

Primary Insurance Company:

ID #:	Group #:	Relation to Subscriber:
Subscriber Name:	Birth Date: / /	Subscriber SS# - -

Secondary Insurance Company:

ID #:	Group #:	Relation to Subscriber:
Subscriber Name:	Birth Date: / /	Subscriber SS# - -

Pharmacy Name:

Phone:

Address: Street City State Zip

☐ I assign all medical/surgical benefits to Center for Colon & Digestive Diseases and understand that I am financially responsible for all charges whether or not they are paid by insurance. I authorize payment to be made to the provider. In the event payment is made to the policyholder, I agree to submit payment in full to this office immediately. If the account is not paid in full, and prior arrangements have not been made, your account(s) may be referred to a collection agency. If your account is referred to an agency, you will be responsible for all attorney's and/or collection fees.

☐ I hereby authorize the doctor to release or procure all information necessary to secure the payments of benefits, for treatment purposes, or to another health care provider or destination at my discretion. I consent to communicate via electronic means for routine matters. I further agree that a photocopy of this agreement shall be as valid as the original. I certify the above information is true and correct to the best of my knowledge. I understand that HIPAA and privacy policies are available online and in the office by request.

☐ I have read and understand the information on this form.

Signature: _____ Date: _____