

# THE CENTER FOR COLON AND DIGESTIVE DISEASE

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PLEASE PRINT

PATIENT REGISTRATION

Social Security # \_\_\_\_\_

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Marital Status:  Single  Married  Legally Separated  Divorced  Widowed Sex:  Male  Female

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

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ May We Call You at Work?  Yes  No

Occupation: \_\_\_\_\_ Are You Self-Employed? \_\_\_\_\_ If Self – Name of Business: \_\_\_\_\_

Employer's Address: \_\_\_\_\_ How Long Employed? \_\_\_\_\_  Full Time  Part Time

Are You a Student? \_\_\_\_\_  Full Time  Part Time

Name of Spouse: \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Can We Call Them at Work if Necessary?  Yes  No Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**If Responsible Party is Other Than Patient, Please Complete:**

Responsible Party Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

DOB: \_\_\_\_\_ Social Security # \_\_\_\_\_ Employer: \_\_\_\_\_  Full Time  Part Time

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

In Case of Emergency, Notify: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Who Referred You to This Office? \_\_\_\_\_

Who Is Your Regular Family Physician? \_\_\_\_\_

Have You Seen Any of Our Doctors Before?  Yes  No If Yes, Whom? \_\_\_\_\_

Do You Have Medical Insurance Coverage?  Yes  No

Primary Insurance Company \_\_\_\_\_ I.D.# \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_ I.D.# \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**If YES, Please Give ALL of Your Cards to the Receptionist, Along With Any Completed Insurance Forms.**

**AUTHORIZATION & ASSIGNMENT: Please Read and Sign the Following Statement:**

I directly assign all medical/surgical benefits to The Center for Colon and Digestive Disease/Huntsville Endoscopy Center and understand that I am financially responsible for all charges not covered by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

It is customary that payment be made when the service is rendered unless prior arrangements have been made in advance. IN the event of non-payment, either by my insurance or myself, I agree to pay all costs of collection, including a reasonable attorney's fee in the event it is necessary to employ an attorney to enforce any provision of this contract. I/We further agree to waiver my/our rights of exemption under the laws of the State of Alabama or of any other state.

Signature: X \_\_\_\_\_ Date: X \_\_\_\_\_