Patient Registration

Welcome to Digestive Disease Associates. We are committed to providing the best, most comprehensive care possible. Please assist us by providing the following information. All information is confidential and is released only with your consent.

PERSONAL INFORMATION: Today's Date _____

Patient Name (last) _____ (first) _____ (m.i.) _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____ Ext. _____

Email _____ Pharmacy _____

Employer Name and Address _____

_____

Social Security Number _____ Date Of Birth ____/____/____ Sex ____ Marital Status _____

Spouse Name _____ Spouse Employer _____

Primary Care Physician (last) _____ (first) _____ City _____ Phone _____

Notify in Case of Emergency _____ Relationship _____ Phone _____

INSURANCE SUBSCRIBER:

Name _____ Date of Birth _____

Relationship to Patient _____ Employer Name and Address _____

_____

GENERAL INFORMATION:

Preferred Language _____ Religion _____

Please Circle:

Interpreter Needed	Yes	No
English Fluency	Yes	No
Ethnicity	Hispanic or Latino	
	Non-Hispanic	
	Refuse	

Race	American Indian & Alaska Native
	Asian
	Black or African American
	Native Hawaiian or Other Pacific Islander
	Other
	Refuse
	White or Caucasian

RESPONSIBLE PARTY IF PATIENT IS A MINOR OR HAS A GUARDIAN:

Name _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell _____ Work _____

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf, I assign the benefits payable to which I am entitled including Medicare, Private Insurance and other Health Plans. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment.

I understand this form and the requested information.

I understand that I am financially responsible for all charges whether or not paid by said Insurance. In the event that this office needs to obtain legal assistance in collection of any unpaid balance, I agree to pay late payment costs and attorney fees as allowable by law and acknowledge receipt of this agreement.

TODAY'S DATE _____ SIGNATURE: _____