

# THE CENTER FOR COLON AND DIGESTIVE DISEASE

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## Patient Registration

### PLEASE PRINT OR CIRCLE ANSWER

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

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

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

Language: (Please give preferred Language) \_\_\_\_\_

### The *enclosed* categories are required for compliance with U.S. Government regulations.

Race:	American Indian/Alaska Native	Asian	Black	African American
	Native Hawaiian	Other Pacific Islander	White	Multicultural
	Refuse to Report	Unknown		
Ethnicity:	Hispanic/Latino	Non-Hispanic/Non-Latino	Decline	Unknown

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

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

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

Employer: \_\_\_\_\_ May we call you at work? (Circle) Yes / No

Self-Employed? (Circle) Yes / No If Self Employed, Name of Business: \_\_\_\_\_

Occupation: \_\_\_\_\_ How Long Employed? \_\_\_\_\_ (Circle) Full / Part

Employer's Address: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_\_

Spouse's Social Security #: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Spouse's Occupation: \_\_\_\_\_ May we call them at work if necessary? (Circle) Yes / No

Spouse's Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

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

Who Referred You to This Office? \_\_\_\_\_ Who is your Family Physician? \_\_\_\_\_

Have You Seen Any of Our Physicians Before? (Circle) Yes / No If Yes, Whom? \_\_\_\_\_

Do you have Medical Coverage? (Circle) 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 Responsible Party is Other than the Patient, Please Complete The following:**

Responsible Party Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Date of Birth: _____ Social Security #: _____
Employer: _____ (Circle) Full / Part
Home Phone: _____ Cell phone: _____ Work Phone: _____

**In order to provide our patients with the highest level of care, any procedure cancellation with less than 48 hour notice may result in a \$75.00 cancellation fee. This cancellation fee is not covered by your insurance. Payment of this fee will be required prior to rescheduling the missed procedure. There will be a \$10.00 administration service charge for filling out any Prior Authorization (P.A.) forms that your insurance company may require in order for you to obtain their approval for prescription medication. This fee must be paid prior to the completion of your P.A. form. There is also a \$15.00 administration fee if you have to be invoiced for your Co-pay.**

**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 Physician/ Practice 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 insurance or myself, I agree to pay all cost 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 hereby authorize any physician or hospital to provide copies of my medical history and treatment to The Center for Colon and Digestive Disease, P.C. Photocopies of this agreement are as good as the original.**

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