



PATIENT REGISTRATION FORM

Date \_\_\_\_\_ Patient Number \_\_\_\_\_

PATIENT INFORMATION (Required data)

Please provide your Driver's License card to the Receptionist to copy.

Form containing patient information fields: Social Security #, Home Address, First Name, Middle, Last Name, Suffix, Gender, Date of Birth, Patient Primary Language, Employment status, Race/Ethnicity, Referring Physician, etc.

INSURANCE INFORMATION (Required data)

Please provide your Insurance card to the Receptionist to copy.

Form containing insurance information fields: Medicare/Medicaid/Commercial/Worker's Comp/Self Pay/Other, Insurance Company, Policy #, Group #, Insured (if other than Patient), Relationship, etc.

PHARMACY INFORMATION:

Form containing pharmacy information fields: Pharmacy, Pharmacy Phone, Address, City/State, Zip

EMERGENCY CONTACT:

Form containing emergency contact fields: Relationship to Patient, Gender, Home Phone, First Name, Last Name, Work Phone

I authorize Digestive CARE to discuss with the above-named Emergency Contact the following issues related to my care:  Medical  Financial

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services.

SIGNATURE (Patient or Parent if Minor) \_\_\_\_\_ Date \_\_\_\_\_

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

SIGNATURE (Patient or Parent if Minor) \_\_\_\_\_ Date \_\_\_\_\_