Columbia Gastrointestinal Endoscopy Center

Please check: ☐ **Bristow** ☐ **Galan** ☐ **Kimbrough** ☐ **Mann** ☐ **Postic** ☐ **Villanueva** **Account #** _____

PATIENT INFORMATION

PATIENT:_____ SOCIAL SECURITY #: _____

ADDRESS:_____ DATE OF BIRTH: _____ AGE: _____

CITY_____ COUNTY_____ Phone: Cell_____HOME_____

STATE_____ZIP_____ Sex at Birth: ☐ Female ☐ Male Marital Status: _____

E-mail Address_____

FAMILY PHYSICIAN and or REFERRING PHYSICIAN _____

RACE: ☐ African America ☐ Caucasian ☐ American Indian ☐ Asian Other_____

ETHNICITY ☐ Hispanic or Latino ☐ Non-Hispanic or Latino HAVE YOU HAD A PREVIOUS PROCEDURE AT OUR CENTER? ☐ Yes ☐ NO

DO YOU HAVE AN ADVANCED DIRECTIVE or LIVING WILL? ☐ Yes ☐ No IF NOT, WOULD YOU LIKE INFORMATION? ☐ Yes ☐ No

PRIMARY INSURANCE INFORMATION

COMPANY _____ PHONE _____

ADDRESS_____ CITY, STATE, ZIP_____

MEMBER # _____ GROUP# _____

NAME OF INSURED_____ INSURED SOCIAL SECURITY _____

INSURED DATE OF BIRTH _____ RELATIONSHIPTO PATIENT

SECONDARY INSURANCE INFORMATION

COMPANY _____ PHONE _____

ADDRESS:_____ CITY, STATE, ZIP

MEMBER # _____ GROUP#

NAME OF INSURED:_____ INSURED SOCIAL SECURITY:_____

INSURED DATE OF BIRTH _____ RELATIONSHIPTO PATIENT

EMPLOYMENT INFORMATION

EMPLOYER _____ PHONE _____

ADDRESS:_____ CITY_____

STATE_____ ZIP_____ CONTACT: _____

EMERGENCY NOTIFICATION

CONTACT:_____ TELEPHONE:_____

RELATIONSHIP:_____ RESPONSIBLE PARTY: _____

I authorize the release of any medical information necessary to process **my insurance claim(s). I authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may** be used in place of the original.

Signed (Patient or Responsible Party)_____ Date_____

Email Address for patient survey_____