Arrowhead Gastroenterology Associates, P.C.

Patient Registration Form

Patient's Last Name: _____ First Name: _____ MI:_____

Address: _____ City: _____ State: _____ Zip: _____

Sex: M[ ] F[ ] __ Student __ Employed __ Other Employer Name: _____

Home Phone Number: (____)_____ Work Phone Number: (____)_____

Date of Birth: ____/____/____ Age: _____ Social Security #: _____

Marital Status: [ ] Married [ ] Single [ ] Other Smoker Y [ ] N [ ]

Referred By: _____ Phone #: (____)_____

Emergency Contact: Nearest friend or relative not living with you:

Name _____ Contact's Daytime phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

If patient is a minor, Guardian's relationship to patient: _____

Guardian's Last Name: _____ First Name: _____ MI: _____

Insurance Policy Information

Primary Insurance Carrier: _____ Policy I.D. #: _____

Insurance Claims Address: _____ Group Name/#: _____

Incurance Co. City: _____ State: ____ Zip: _____ Phone #: (____)_____

Policy Holder: _____ Relationship to patient: _____

Policyholder Primary Insured Party Information

If you need more space (for more than one plan) please ask the receptionist for another sheet

Insurance Policy: __ Primary __ Secondary Policyholder's social security #: _____

Policyholder's Last Name: _____ First name: _____

Sex: __M __F Birthdate: ___/___/___ Relationship to patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone Number: (____)_____ Work Phone #: (____)_____

Employer Name: _____ IS this policy under the employers plan? [ ] Y [ ] N

Secondary Insurance Carrier _____ Policy I.D. #: _____

Insurance Claims Address: _____ State: _____ Zip: _____

Insurance Co. city: _____ State: _____ Zip: _____ Phone #: _____

Policyholder: _____ Relationship to patient: _____

As a responsible part, I agree that all charges that are not directly paid by my insurance will be my responsibility. I hereby authorize payment of medical benefits to Arrowhead Gastroenterology Associates, P.C. to release any information necessary to complete and process my insuranc claims. In the event that my account is turned over to a collection agency for no-payment or other or other delinquency, I agree to pay court costs, attorney fees, and up to 50% of collection fees on any outstanding balances over 90 days.

SIGNATURE _____ DATE ____/____/____