# PATIENT REGISTRATION FORM

Patient Name: _____ **Sex**: **Male** ☐ **Female** ☐

Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____

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

Home Phone #:( _____ ) _____-_____ Cell #: ( _____ ) _____-_____ Work #:( _____ ) _____-_____

**Preferred Method of Contact:** Mail ☐ Phone ☐ E-Mail ☐ MyChart* ☐ *ask us how to obtain access to MyChart

E-Mail Address: _____

**Marital Status**: Single ☐ Married ☐ Divorced ☐ Widowed ☐

**Ethnic Group**: Hispanic/Latino ☐ Non Hisp/Latino ☐ Unknown ☐

**Religion**: _____ **Race:** _____ **Preferred Language** : _____

**Employed:** Full-Time_____ Part-Time_____ Other_____ **Employer:** _____

**Emergency Contact Information**:

Name: _____Relationship: _____

Home Phone #:( _____ ) _____-_____ Cell #: ( _____ ) _____-_____ Work #:( _____ ) _____-_____

**Primary Insurance:**

Insurance Carrier: _____ Claims Address: _____ Phone: _____

I.D. #:_____GRP#:_____ Effective date of policy:_____

Policy Holder DOB:____/___/_____Relation to Policy Holder:_____ Name of Policy Holder:_____

**Secondary Insurance: (if applicable)**

Insurance Carrier: _____ Claims Address: _____ Phone: _____

I.D. #:_____GRP#:_____ Effective date of policy:_____

Policy Holder DOB:____/___/_____Relation to Policy Holder:_____ Name of Policy Holder:_____

***********If you have any **additional insurance** information, please write it on the **back** of this form and notify the receptionist.*********

**Visit Information:**

Referring/Primary Doctor: _____ Phone: _____

Reason for Visit:: _____

Name of Pharmacy: _____ Phone Number:_____

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

***********Authorization for Treatment*********

*In signing below, I authorize Centers for Digestive Health to examine, diagnose and treat me or the named patient including a minor, giving reasonable and proper medical care by today's standards. I authorize and give consent to provide treatment that may include submission of specimens (blood, urine, tissue, etc.) to the laboratory(ies) of choice for analysis and study and to include diagnosis for submission for payment to the insurance carrier for me or the named patient. I understand that if the insurance information given on this form is incorrect or not valid, I am responsible for the charges.*

*Patient/Guardian signature*_____