Carolina Digestive Health Associates, PA

For office use:	Date:__________ Intitals ______
Physician: ______________	Account # ______________

Patient Information

Patient Name (Last) | (First) | (Middle Initial) | Social Security # | Date of Birth

☐ Male -or- ☐ Female | ☐ S ☐ M ☐ D ☐ W Maritial Status | Home Phone # *** | Cell #

Address (Street) | (City) | (State) | (Zip Code) | Work Phone #

Primary Physician Name | Office Address | Office Phone #

Referring Physician Name if different ⇨ ______________________

FOR PEDIATRIC PATIENTS, PLEASE COMPLETE BELOW

Responsible Party Name (Last) | (First) | (Middle Initial) | Home Phone #

Address (Street) | (City) | (State) | (Zip Code) | Work Phone #

Insurance & Policy Holder Information

Primary Insurance Information	**Secondary Insurance Information**
Insurance Company Name	Insurance Company Name
Policy Holder Name	Policy Holder Name
Social Security # / Date of Birth	Social Security # / Date of Birth
Employer	Employer
Employer Street Address	Employer Street Address
Employer City, State, Zip Code	Employer City, State, Zip Code
Employer Phone #	Employer Phone #
Patient Relationship to Policy Holder	Patient Relationship to Policy Holder

Emergency Contact

Name | Phone Number | Relationship to Patient

I give permission to release medical information necessary to my insurance company for payment of claims and assign benefits to Carolina Digestive Health Associates, PA. I understand I am financially responsible for charges not covered by these insurance carriers. Reminders for appointments and procedures may be sent by mail to remind me to call for scheduling. ***A voice mail message will be left on this number for appointment reminders.

Patient/Guarantor Signature: ______________________ Date: ______________