

REGISTRATION FORM

<i>For office use:</i>	Date: _____	Intitals _____
Physician: _____	Account # _____	

Patient Information

Name (Last) _____	(First) _____	(Middle Initial) _____	Social Security # _____	Date of Birth _____
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W	Home Phone # _____		Cell Phone# _____
Marital Status		Work Phone# _____		
Address (Street) _____	(city) _____	(state) _____	(Zip Code) _____	Work Phone# _____
Primary Physician Name _____	Office Address _____	Office Telephone# _____		
Referring Physician Name if different _____	Patient E-Mail _____			
Pharmacy _____	Phone _____			

Insurance and Policy Holder Information

Primary Insurance Information

Insurance Company Name _____
Policy Holder Name _____
Date of Birth _____
Insurance ID # _____
Insurance Group # _____
Employer _____
Employer Street Address _____
Employer City, State, Zip Code _____
Employer Telephone # _____
Patient Relationship to Policy Holder _____

Secondary Insurance Information

Insurance Company Name _____
Policy Holder Name _____
Date of Birth _____
Insurance ID # _____
Insurance Group # _____
Employer _____
Employer Street Address _____
Employer City, State, Zip Code _____
Employer Telephone # _____
Patient Relationship to Policy Holder _____

Emergency Contact

Name _____	Phone Number _____	Relationship to Policy Holder _____
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I give permission to Carolina Digestive Health Associates, PA to treat me at each visit and suggest further treatments as they deem necessary. 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: _____