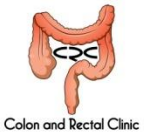

New Patient Registration

Name: _____ _____ _____DOB:_____ Age: _____
Last Name First Name Middle Initial
SSN: _____ Sex: M___/F___ Marital Status: S/M/D/W
Address: _____ _____
Number Street Suite # City State Zip Code
Home phone: _____Cell/Pager: _____Work Phone: _____
Email: _____ Height: _____ inches Weight: _____Lbs

Emergency Contact: Name: _____Relationship:_____Phone:_____

Race: ❑American Indian/Alaskan Native ❑Asian ❑ Black/African American ❑ Native Hawaiian/Other Pacific Islander ❑White ❑ Other Race ❑ Unknown ❑ Declined

Ethnicity: ❑ Hispanic or Latino ❑ Non-Hispanic or Latino ❑ Declined ❑ Unknown

Pharmacy: _____ Telephone number of the Pharmacy: _____
Address: _____ _____
Number Street Suite # City State Zip Code
Patient Employer: _____Occupation: _____
Employer Address: _____
Number Street Suite # City State Zip Code
Emergency Contact: _____
Name Phone/Cell Relationship

Insurance Information

Primary Insurance Company: _____
Patient ID #: _____ Group #: _____
Secondary Insurance Company: _____
Patient ID #: _____ Group #: _____

Guarantor Information

Person responsible for account: _____Relationship to Pt.: Self/Spouse/Father/Mother/Child
Address: _____
Phone #: _____ SSN: _____ DOB: _____ Sex: _____
Employer: _____Employer Address: _____Phone: _____
Name of the Doctor who referred you to us_____/Primary Care Physician_____

Assignment and Release/ Receipt of Physician Notice of Privacy Practice/ Authorization

I certify that I, and/or my dependent(s), have the above mentioned insurance coverage and assign directly to Colon and Rectal Clinic and its providers all insurance benefits. I understand that I am financially responsible for all charges, including co-pays, deductibles, non-covered charges and any other charges payable for services rendered and not paid by insurance within 60 days. I authorize the use of my signature on all insurance submissions. I authorize Colon and Rectal Clinic to use my health care information and disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. I acknowledge that I voluntarily sought treatment and accept any procedure deemed necessary by the physician. I am aware that a copy of the privacy notice, which explains how my health information, will be provided at my request and is visible at the office setting. I understand that the physician reserves the right to revise this and make the revised notice available to me in the office. I have also read and agree to the financial and practice policy of Colon and Rectal Clinic, LLC. In the event that I am not at home/work, I authorize that the physician or his/her staff to leave messages on answering machines or with a family member. I understand that I have the right to revoke or modify all of the above. A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____ _____
Printed Name of Patient/Guardian Signature of Patient/Guardian Date

Please give your Primary and Secondary insurance cards to the receptionist so that we may make a copy for our records.

FOR OFFICE USE ONLY

Consent received by _____on _____.