

Patient Registration Form

Patient Information

Your Name: _____ Birth Date: _____ Gender: _____
 (First) (MI) (Last)
 Marital Status: Single Married Divorced Widowed Separated Other Social Security #: _____ - _____ - _____
 Address: _____ City: _____ State: _____ Zip: _____
 Primary Phone: _____ H W C Secondary Phone: _____ H W C
 May we text you appointment reminders? Yes No Email: _____
 Referring Physician: _____ Primary Care Physician: _____

Optional Questions

Preferred Language: _____ Race: American Indian/Native Alaskan Black/African American
 Asian Native Hawaiian/Pacific Islander White Other Are you Hispanic/Latino?: _____

Responsible Party ☐ Self

Name: _____ Address: _____
 City: _____ State: _____ Zip: _____ Phone: _____ H W C

Emergency Contact ☐ I authorize Arizona Digestive Health to release health information to my Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Additional Information

Occupation: _____ Employer: _____
 How Did You Hear About Us?: ☐ Friend/Family ☐ Our Website ☐ Primary Care Physician ☐ Google/Search Engine Results
☐ Social Media ☐ Radio ☐ Television ☐ Magazine/Other Publication ☐ Online Review/Rating Site

Insurance Information

Primary Insurance Company: _____ Relation to Subscriber: _____
 ID #: _____ Group #: _____
 Subscriber Name: _____ Birth Date: _____ Subscriber SS#: _____ - _____ - _____
Secondary Insurance Company: _____ Relation to Subscriber: _____
 ID #: _____ Group #: _____
 Subscriber Name: _____ Birth Date: _____ Subscriber SS#: _____ - _____ - _____

Pharmacy

Name: _____ Phone: _____
 Address: _____ City: _____ Zip: _____

☐ I assign all medical/surgical benefits to Arizona Digestive Health, P.C. and understand that I am financially responsible for all charges whether or not they are paid by insurance. I authorize payment to be made to the provider. In the event that the payment is made to the policyholder, I agree to submit payment in full to this office immediately. If the account is not paid in full, and prior arrangements have not been made, your account(s) may be referred to a collection agency. If your account is referred to an agency, you will be responsible for all attorney's and/or collection fees.

☐ I hereby authorize the doctor to release or procure all information necessary to secure the payments of benefits, for treatment purposes, or to another health care provider or destination at my discretion. I may revoke this authorization at any time in writing, with the exception of insurance disclosures for billing purposes. I consent to communicate via electronic means for routine matters. I further agree that a photocopy of this agreement shall be as valid as the original. I certify the above information is true and correct to the best of my knowledge. I understand that HIPAA and privacy policies are available online and in the office by request.

☐ I have read and understand the information on this form.

Signature

Date