PATIENT INFORMATION FOR MEDICAL RECORDS (PLEASE PRINT)

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. MARITAL STATUS _____

NAME: LAST_____ FIRST_____ MI_____

HOME ADDRESS_____CITY_____STATE_____ ZIP_____

DATE OF BIRTH _____/_____/_____ AGE_____ M / F Drivers License# _____State_____

HOW WOULD YOU LIKE TO BE ADDRESSED? (Nickname, First Name, Last Name and/or Title)_____

CONTACT #'S: HOME (_____) _____WORK (_____) _____CELL (_____) _____

OKAY TO LEAVE TEST RESULTS ON ANSWERING MACHINE? _____YES _____NO

PREFERRED PHONE NUMBER TO LEAVE A DETAILED MESSAGE (_____) _____

EMPLOYED BY_____OCCUPATION_____

SPOUSE NAME: LAST _____FIRST_____OCCUPATION_____

FRIEND OR NEAREST RELATIVE NOT LIVING WITH YOU_____PHONE (_____) _____

WHO REFERRED YOU TO THIS OFFICE? _____

WHO IS YOUR PRIMARY DOCTOR? _____PHONE (_____) _____

WHAT PHARMACY DO YOU USE? _____PHONE (_____) _____

PHARMACY ADDRESS: _____

MEDICAL INSURANCE INFORMATION (NOTE: CO-PAYMENT IS DUE AT TIME OF SERVICE)

NAME OF INSURANCE COMPANY_____

POLICY/ID # _____GROUP NAME/NUMBER _____

SOCIAL SECURITY NUMBER _____--_____--_____

PLEASE SIGN AND RETURN TO RECEPTIONIST

I, THE UNDERSIGNED, HAVE INSURANCE COVERAGE WITH _____ AND ASSIGN DIRECTLY TO
NAME OF INSURANCE COMPANY
_____ ALL SURGICAL AND/OR MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED.
NAME OF PHYSICIAN TREATING YOU

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. *Note: the physicians of San Diego Digestive Disease Consultants reserve the right to impose a $25.00 fee for appointments cancelled without 24 hours notice. If you need to cancel or reschedule a procedure, we ask that you give us seven days notice. We reserve the right to impose a $100.00 fee for the cancellation of a procedure without at least 72 hours notice.*

DATE: _____SIGNED_____