WestGlen Endoscopy Center
16663 Midland Drive
Shawnee, KS 66217

Patient Information

Today's Date:_____ DL #:_____

Legal Name:_____ Age:_____ DOB: _____ Sex_____

Address: _____ SS#_____

City: _____ State: _____ Zip:_____ email: _____

Home Phone:_____ Work Phone: _____ Cell Phone: _____

Patient Employer: _____ Referring Physician:_____

EMERGENCY INFORMATION

Name: _____ Relationship:_____

Phone: _____

Insurance Policy Holder Information

Insured's Name: _____ Insured's DOB:_____

Insured's ID #: _____ Insured's Employer: _____

Verification of Coverage

Date of Procedure: _____ Time: _____ Procedure: _____ Physician:_____

Diagnosis: _____

Circle One: Primary Secondary Temporary Date Coverage effective: _____

Insurance Company: _____ ID # _____ Grp #: _____

Lab Card: Yes No Lab Name: _____

Circle One: HMO PPO POS Commercial WorkComp Liability Other: _____

Contact Person: _____ Phone: _____

Precert needed: Yes No Authorization Number: _____

Benefits / Liability

FACILITY IN NETWK	FACILITY OON	ANESTHESIA IN NETWK	ANESTHESIA OON
Deduct?	Deduct?	Deduct?	Deduct?
Met?	Met?	Met?	Met?
80/20 co-pay:	80/20 co-pay:	80/20 co-pay:	80/20 co-pay:
Ind OOP Max:	Ind OOP Max:	Ind OOP Max:	Ind OOP Max:

Financial Arrangements:

_____

Secondary Insurance Information

Insurance Company: _____ ID: _____ Group:_____