Columbia Gastrointestinal Endoscopy Center
PATIENT DEMOGRAPHIC FORM
PLEASE PRINT

PATIENT INFORMATION

PATIENT:_____ SOCIAL SECURITY #: _____

ADDRESS:_____DATE OF BIRTH: _____ AGE: _____

CITY_____ COUNTY_____ Phone: HOME_____Cell_____

STATE_____ZIP_____FEMALE_____MALE_____MARITAL STATUS_____

E-mail Address_____Drivers License #_____

FAMILY PHYSICIAN (REFERRING PHYSICIAN _____

HAVE YOU HAD A PREVIOUS PROCEDURE AT OUR CENTER? YES NO (PLEASE CIRCLE ONE)

DO YOU HAVE A LIVING WILL? YES NO WOULD YOU LIKE INFORMATION? YES NO

EMPLOYMENT INFORMATION

EMPLOYER _____ PHONE _____

ADDRESS:_____CITY_____

STATE_____ ZIP_____CONTACT: _____

PRIMARY INSURANCE INFORMATION

COMPANY _____ PHONE _____

ADDRESS_____CITY, STATE, ZIP_____

MEMBER # _____ GROUP# _____

NAME OF INSURED_____INSURED SOCIAL SECURITY _____

INSURED DATE OF BIRTH _____RELATIONSHIPTO PATIENT_____

SECONDARY INSURANCE INFORMATION

COMPANY _____ PHONE _____

ADDRESS:_____CITY, STATE, ZIP_____

MEMBER # _____ GROUP#_____

NAME OF INSURED:_____INSURED SOCIAL SECURITY:_____

INSURED DATE OF BIRTH _____RELATIONSHIPTO PATIENT_____

EMERGENCY NOTIFICATION

CONTACT:_____TELEPHONE:_____

RELATIONSHIP:_____ RESPONSIBLE PARTY: _____

RELEASE OF AUTHORIZATION/ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to my physicians. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in place of the original.

_____ _____/_____/_____

Signed (Patient or Responsible Party) Date