Oak Lawn Endoscopy

PLEASE PRINT. Read all sections carefully, all information will be kept confidential!

Date_____ Patient Name _____

Address _____City _____ State____ Zip_____

County _____ SS # _____ Date of Birth _____

Home Phone # (_____) _____ _____Male _____Female

Patient's Employer _____Work Phone (_____)_____

Occupation_____

Marital Status (circle one): Single Married Widowed Divorced

Spouse's name _____

Name of referring physician_____ Phone number_____

Race: **(Please check one)** ___American Indian/Alaska native ___Asian ___Black/African American

___Native Hawaiian or Pacific Islander ___White

Ethnicity: Hispanic/Latino? _____Yes _____No **(Please check one)**

PRIMARY INSURANCE INFORMATION

PRIMARY CARDHOLDER NAME_____

SS# _____Date of Birth _____ Relationship to patient _____

Insurance Company _____

Address for filing claims_____

Policy/ID # _____ Group # _____

Do you have any additional insurance? _____YES _____NO
If **YES**, complete the following:

SECONDARY INSURANCE INFORMATION

PRIMARY CARDHOLDER NAME_____

SS# _____Date of Birth _____ Relationship to patient _____

Insurance Company _____

Address for filing claims_____

Policy/ID # _____ Group # _____

ASSIGNMENT OF BENEFITS

Your signature is necessary for us to process any insurance claims and to ensure payment for services rendered.

I request that payment of authorized insurance benefits be made to me or on my behalf to Oak Lawn Endoscopy for any services furnished to me by the provider. I authorize the release of medical information to insurance carriers concerning my illness and treatment necessary to determine benefits. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.
I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

_____
Please print patient name

_____ _____
Signature of patient **Date**

ATTN: RETIREES: Medicare requires the name of your place of employment at the time of your Retirement

Name of former employer _____

Date of Retirement _____

OAK LAWN endoscopy

PATIENT MEDICATION INFORMATION

Please list all medications (prescriptions and over the counter) below. Please sign below.

Date of Procedure								
Allergic to:					Type of Reaction			
Please list all medications below					*Discharge Instructions: What to do after you leave*			
Medication Name	Dose	Route	How Often	Last Dose Taken	Continue	Stop	New Medication	Additional Instructions

Medication History Recorded/Verified by: _____ Physician's Signature: _____

Discharge Associate Signature: _____ Patient/Responsible Party Signature: _____