University Endoscopy Center
Patient Registration Form

(Please Print)

PATIENT INFORMATION					
Patient's Last Name:		**First Name:**			**Middle Name:**
Birth date:	**Age:**	**Sex:** ❑ Male ❑ Female	**Marital status (circle one):** Single / Mar / Div / Sep / Wid		**Home Telephone:**
Street Address:					**City:**
State:	**ZIP Code:**	**County:**	**Email Address:**		
Cell Telephone:		**Employer:**			**Employer Telephone:**
Is Patient in Skilled Nursing Facility		❑ Yes ❑ No	**Name of Facility:**		

PRIMARY INSURANCE INFORMATION				
Please give your insurance card(s) to the receptionist.				
Insurance Company:	**Effective Date:**	**Subscriber Name:**		**Subscriber Date of Birth:**
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other
Subscriber Social Security Number:	**Policy Number:**			**Group Number:**
SECONDARY INSURANCE INFORMATION				
Insurance Company:	**Effective Date:**	**Subscriber Name:**		**Subscriber Date of Birth:**
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other
Subscriber Social Security Number:	**Policy Number:**			**Group Number:**

WHOM TO NOTIFY IN CASE OF EMERGENCY			
Name of Friend or Relative:	**Relationship to Patient:**	**Home Telephone:**	**Cell Telephone:**

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS:

I authorize the release of any medical information necessary to process any insurance claims. I authorize payment of medical benefits directly to University Endoscopy Center for myself or my dependents. I understand that I am responsible for any Deductibles, Co-Pays, Co- Insurance or other amounts not covered by my insurance policies. If a referral or authorization is required and is not present at the time of service, my procedure will be rescheduled until such time the referral/authorization is obtained. **For any returned checks there is an additional charge.**

Patient/Guardian signature *Date*