Airport Endoscopy Center

Patient & Insurance Information Record

Patient Information

Last Name: ______________________________ First: ______________________ MI: __________

Address: ____

City: _____________________________________ State: ____________________ Zip: ___________

Home Phone: _______________ Work Phone: ______________ Cell Phone: __________________

DOB: ________________ Marital Status: __________________ Male/Female: _______________

Social Security # _________________________ Race: ____________ Ethnicity: ________________

Emergency Contact Name: ___________________________________ Phone: _________________

Employer Name: ____ Phone: __________________

Employer Address: ___________________________________ State: ________ Zip: ____________

Referring Physician: _______________________________ Phone: ___________________________

Responsible Party: _________________________________ Phone: __________________________

Primary Insurance Information

Insurance Company: _______________________________ Phone: __________________________

Policy #: ______________________ Group #: __________________ Precert #: _______________

Insured's Name: ___________________________________ Social Security #: ________________

Insured's DOB: ______________________ Employer: _____________________________________

Claims Address: _____________________________ State: ____________ Zip: _________________

Secondary Insurance Information

Insurance Company: _______________________________ Phone: __________________________

Policy #: ______________________ Group #: __________________ Precert #: _______________

Insured's Name: ___________________________________ Social Security #: ________________

Insured's DOB: ______________________ Employer: _____________________________________

Claims Address: _____________________________ State: ____________ Zip: _________________

Patient/Guarantor Signature: ___________________________________ Date: _________________